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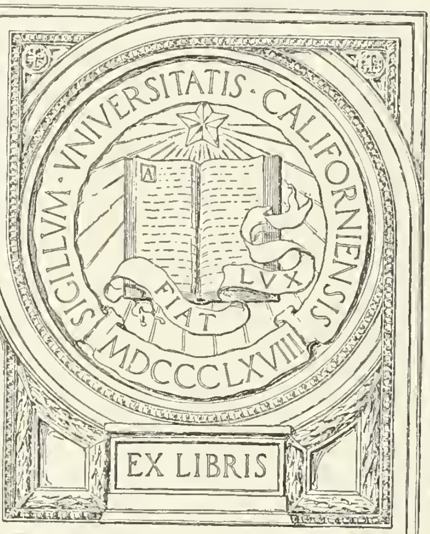
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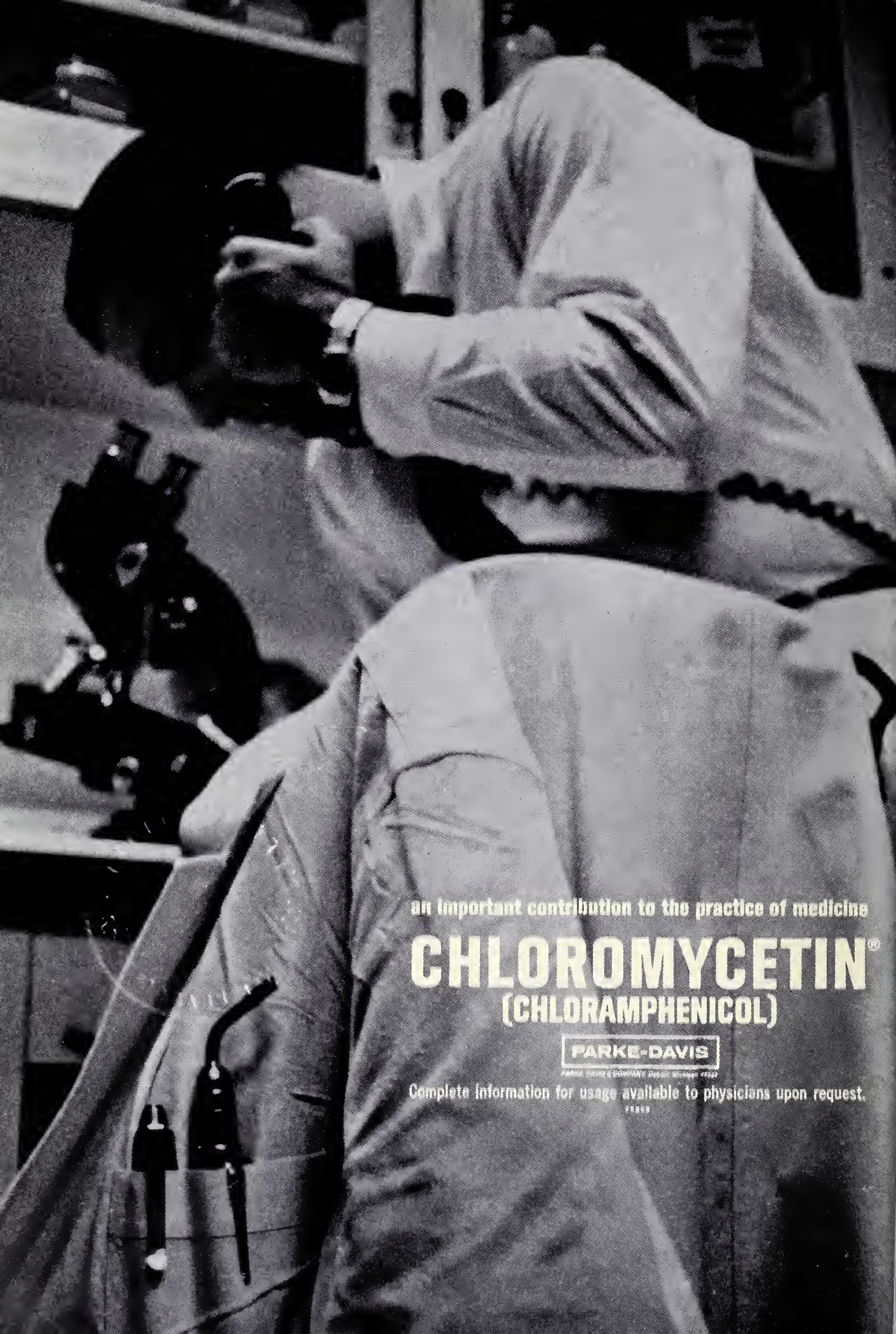

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(1) Frykman, H.M.: Minn. Med., Vol. 38, Jan. 1955. (2) Poth, E.J.: The J.A.M.A., Vol. 163, No. 15, April 13, 1957. (3) McGivney, J.: Texas State Jour. of Med., Vol. 51, No. 1, Jan. 1955. (4) Stern, F. H.: Jour. of The Amer. Ger. Soc., Vol. 11, No. 3, Mar. 1963. (5) Weekes, D. J.: N.Y. State Jour. of Med., Vol. 58, No. 16, Aug. 1958. (6) Abbott, P.L.: Jour. of Oral Surg., Anes. & Hosp. Dental Serv., Vol. 19, July 1961. (7) Weekes, D. J.: E.E.N.T. Digest, Vol. 25, No. 12, Dec. 1963.

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Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

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Before prescribing, consult package circular.

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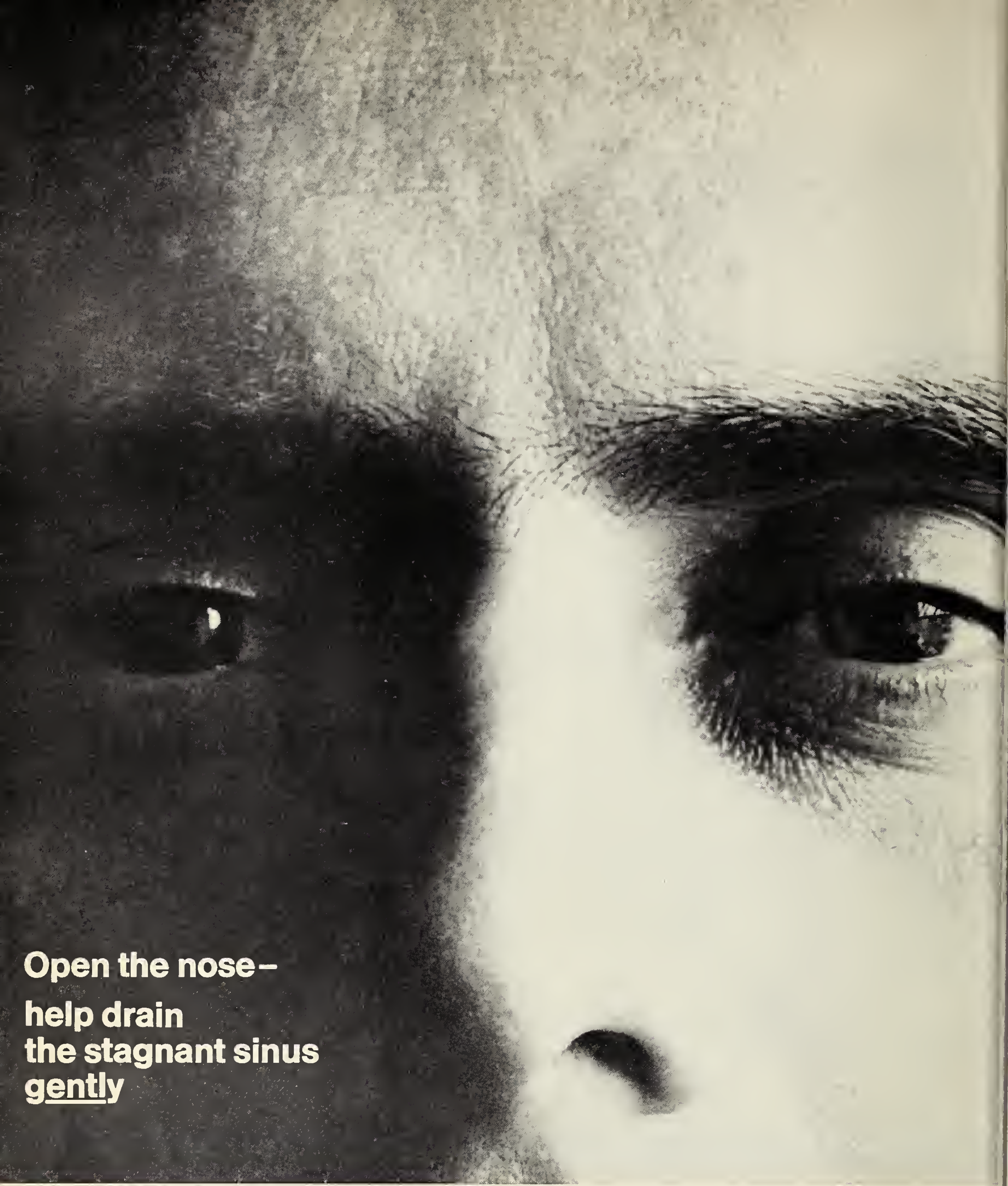

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*Proctor, D. F.: The Nose, Paranasal Sinuses, an Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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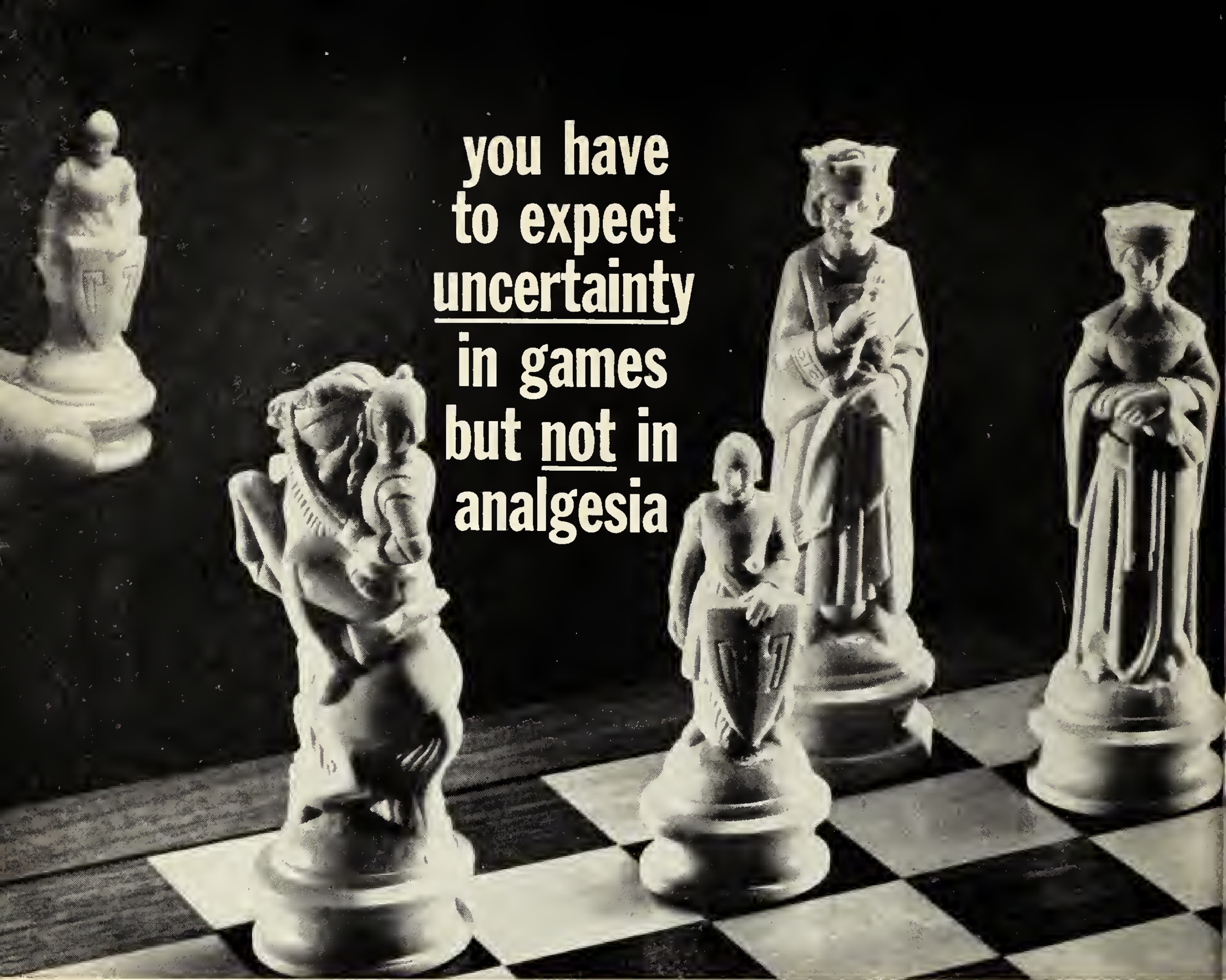
ublished monthly, except two extra issues to be published in October and December, by the Michigan State Medical Society its official journal at 2642 University Ave., Saint Paul, Minn. 55114. Second class postage paid at Saint Paul, Minnesota. arly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, 50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exnges, etc., should be addressed to Publication Committee. Michigan State Medical Society, 120 West Saginaw Street, East nsing, Michigan 48824. © 1965 Michigan State Medical Society.



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HE FORUM QUESTION THIS MONTH:

"Do you think the young doctor today has a different attitude toward social problems than does the older doctor; and if so, why?"

F. C. SABIN, M.D.
Marquette

N. D. HENDERSON
M.D.
Lansing

R. E. WUNSCH
M.D.
Traverse City

(Editor's Note: This Forum Page begins a new ature in MICHIGAN MEDICINE. *Several physicians ere asked to express their views regarding a se- cted question to get this feature started. Now, l MSMS members are invited to react to the next uestion listed below in the box. MSMS members so are always welcome to contribute Guest Edi- rials or to send a memo to the From the Mail Box ature.)*

THE ANSWER I think is yes. The past three de- des have been an age of great change shaped by eral social legislation, the emergence of the lonial nations and the American Negro to free- om, and great scientific knowledge accumulation. nfortunately, humans don't change as fast as ideas d many of our citizens have come to believe in nta Claus—the something for nothing syndrome. edical school curricula contained courses in social rk. The percentage of patients under various elfare programs has increased—with the paper rk enough to make a physician aware of social oblems. Older voters have pressure grouped Med- re into existence, with more sure to come in time. This constant press coverage of individual rights ften with no recognition of the concomitant du- s) has made the young doctor more aware of cial work and more tolerant of the welfare pro- am.

—F. C. Sabin, M.D.
Marquette

OF COURSE, the young doctor has a different at- ude towards social problems than his older col- ague. The traditional attitude of our profession s been that social problems presented to the physician should be handled individually. It did not matter if this was a drinking problem, an illegitimate pregnancy or a disrupted family.

Today, the young physician is taught to deal through one or more organizations, private or governmental. As a result, he is, by nature of the third party relationship, removed from the direct personal contact with the problem and in many cases from the eventual solution to the problem. As a result he finds himself in the isolated position of clinician rather than the family or individual counselor.

This situation is now the way of life in our modern society. It is hoped that the young doctor will not lose sight of his importance to his patients with social problems and will extend sympathy and understanding to those in need of help.

—N. D. Henderson, M.D.
Lansing

What Are Your Views?

Your opinions are invited for this new Forum feature in MICHIGAN MEDICINE. The question for the March issue will be "How Can Medical Schools Interest More Students in General Practice."

Write down your suggestions in a letter and mail before January 25th to Michigan Medicine, 120 West Saginaw Street, East Lansing.

B. M. Harris, M.D.
Chairman, Publications Committee

I BELIEVE the young doctor today definitely has a different attitude toward social problems than the older doctor in several regards.

The social economic problems of medicine find the younger physician less of a free enterprise enthusiast than the older physician because he has been raised in our present increasingly paternalistic and government dominated society. He is accordingly less aware of how much has already been lost to medicine and the public and, therefore, is less willing to enter the fray.

The younger physician feels more involved in community problems than the older doctor but, I believe, he is reticent to involve himself because of the change in patient-physician relationship and "Physician Image" developing insidiously over the last 25 years in America. This change has resulted partly from increasing emphasis on research, and less emphasis on bedside medicine and personal relationship with patients. It has also evolved from continuing socialistic pressure against the profession in all forms of communication and the depersonalizing effects of metropolitan living. Another factor is increasing public knowledge of advances in medical fields resulting in a clamor for delivery of these benefits combined at the same time with complaints of loss of personal warmth from the medical profession.

I believe the younger physician is more willing to endeavor to find psychiatric and social agency help for his patients than the older physician, as a result of his increased education in these areas and the changing concepts of social conscience in our country. In this area, it would appear he should outstrip his older colleagues.

—R. E. Wunsch, M.D.
Traverse City

SOCIAL PROBLEMS as they relate to the medical profession are probably facing our entire people, and attitudes are not necessarily related to age.

However, the attitude of conservatism seems well identified with the medical profession. An attitude born of a lifelong concentration upon individuals rather than groups, and of economic well-being. The older physician has been conceived and nurtured in an era of individual responsibility and of lack of governmental participation in our daily lives. The natural resistance to change is a vein forced by past success and contentment with a well-ordered world that he can understand and with which he can cope professionally and personally.

The younger physician has been conceived and nurtured in an era of social ferment, a yeasty period of social change that accelerates with each passing year. He is made aware throughout his educational experience, both formal and informal, of the restless forces that demand adaptation or obsolescence.

Being young creates parallel lives of force increasing his social awareness and prompting his responses. He is able to adapt more readily, he has less total investment in the status quo, he is less afraid of orderly change, he is committed to a sense of community involvement and, probably as important as any other, he realizes that he must live in a new social atmosphere for 30 years rather than 10 years more of endeavor faced by his older colleagues.

—B. C. Payne, M.D.
Ann Arbor, Michigan

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Fourteen new medical schools are expected to be in operation in the United States by 1970. Some 800 to 1,000 new positions will be available to qualified medical applicants to meet the urgent national need for more physicians.

At least 10 other institutions seem to be reasonably good possibilities to follow through with the development of a new (medical) school.

Over the past 20 years, the number of medical schools has increased steadily from 77 schools in 1945 to 88 in 1965.

Eight of the 14 schools being planned will provide full four-year programs leading to the M.D degree. The other six are planned as two-year schools of the basic medical sciences.

The recently published 65th annual report on medical education by the AMA's Council on Education lists the following as new schools:

The four-year schools: The University of Arizona College of Medicine, Tucson; University of California, San Diego, School of Medicine; University of Connecticut School of Medicine, Farmington Milton S. Hershey Center, Pennsylvania State University, Hershey; Mt. Sinai School of Medicine New York City; South Texas Medical School, University of Texas, San Antonio; University of Massachusetts, and Toledo State College of Medicine Toledo, Ohio.

The two-year schools: Brown University Program in Medical Science, Providence, R. I.; University of Hawaii Medical School, Honolulu; Michigan State University College of Human Medicine; Rutgers University Medical School, New Brunswick, N. J. University of California at Davis, and the University of New Mexico School of Medicine, Albuquerque.

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You might also say that all interns aren't alike, either.

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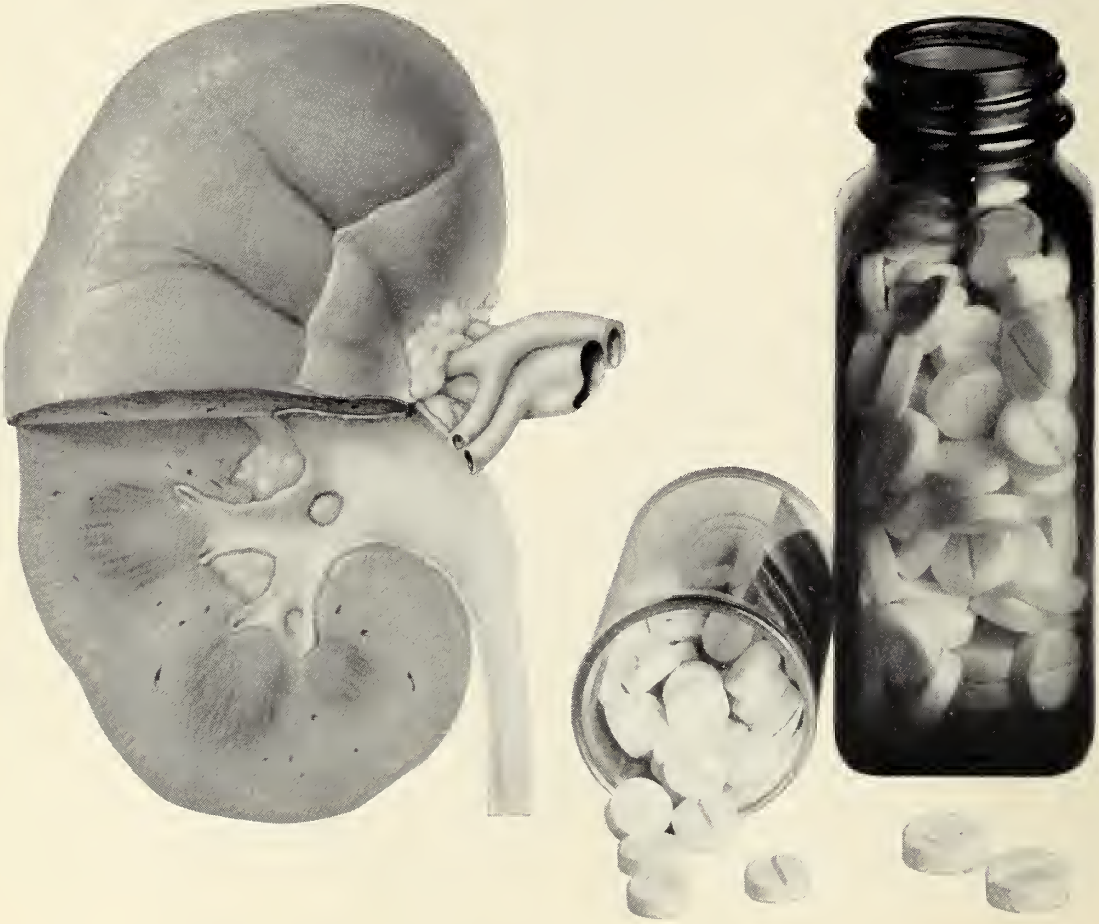

understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

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- From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

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Chairmen Named for New Year

MSMS committee chairmen for 1965-66 have been appointed and are busy planning projects and activities for the new year.

Those appointed by MSMS President Luther R. Leader, M.D., include: Advisory Committee to Michigan State Medical Assistants Society, G. E. Millard, M.D., Detroit; Advisory Committee to Woman's Auxiliary, R. H. Reitzel, M.D., Mt. Clemens; Aging, A. Hazen Price, M.D., Detroit; Annual Session Program Committee, H. A. Towsley, M.D., Ann Arbor; Blood Banks, L. W. Walker, M.D., Lansing; Cancer, M. J. Brennan, M.D., Grosse Pointe; Cardiac Disease Control, S. E. Chapin, M.D., Dearborn.

Child Welfare, F. J. Margolis, M.D., Kalamazoo; Highway Accident Prevention, P. W. Gikas, M.D., Ann Arbor; Iodized Salt, B. E. Brush, M.D., Detroit; Legal Affairs, Otto K. Engelke, M.D., Ann Arbor; Maternal Health, W. W. Jack, M.D., Grand Rapids; Medical Socio-Economics, H. F. Falls, M.D., Ann Arbor; Medicine and Osteopathy, J. J. Coury, M.D., Port Huron; Mental Health, Benjamin Jeffries, M.D., Harper Woods; Occupational Health, William Jend, Jr., M.D., Detroit;

Postgraduate Medical Education, H. A. Towsley, M.D., Ann Arbor; Professional Insurance Plans, Fredrick Weissman, M.D., Southfield; Public Health, O. D. Stryker, M.D., Mt. Clemens; Public Relations, Brock E. Brush, M.D., Detroit; Respiratory Diseases, R. A. Rasmussen, M.D., Grand Rapids; Rural Medical Service, R. E. Rice, M.D., Greenville; Venereal Disease Control, F. B. Bicknell, M.D., Detroit.

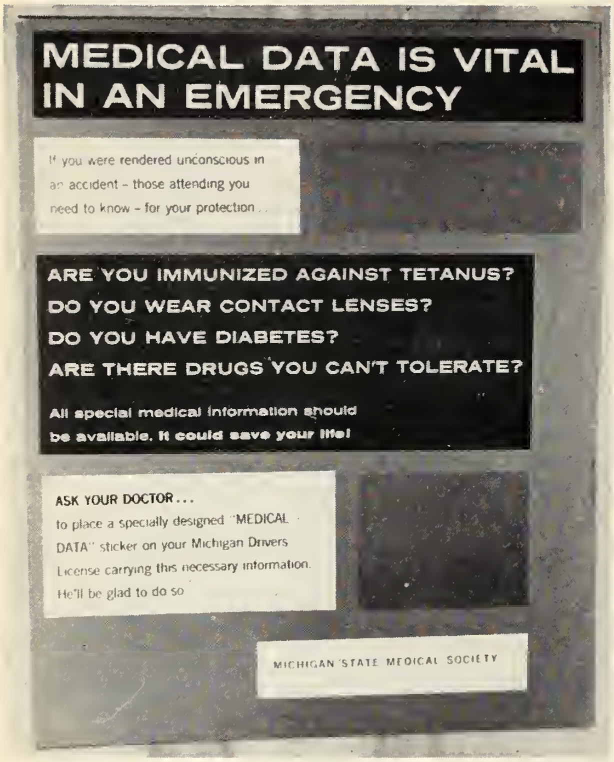
* * *

THOSE APPOINTED by MSMS Council Chairman Harold H. Hiscock, M.D., include Education Liaison Committee, Don Marshall, M.D., Kalamazoo; Liaison with State Board of Registration in Medicine, K. H. Johnson, M.D., Lansing; Liaison Committee with Michigan State Pharmaceutical Association, R. V. Daugharty, M.D., Cadillac; Liaison Committee with State Bar of Michigan, W. M. LeFevre, M.D., Muskegon; Liaison Committee with Michigan Crippled Children Commission, A. C. Stander, M.D., Saginaw; Liaison Committee with State Executive Office, K. H. Johnson, M.D., Lansing; Liaison Committee with Michigan Hospital Service, H. H. Hiscock, M.D., Flint; Liaison Committee with Residents, Interns, Medical Students, N. D. Henderson, M.D., East Lansing;

Alcoholism and Drug Addiction, R. C. Bates, M.D., Lansing; Awards, Wm. A. Hyland, M.D., Grand Rapids; Beaumont Memorial, R. J. Mason, M.D., Birmingham; Courses on Medical Economics and Ethics, R. O. Kraft, M.D., Ann Arbor; Disaster Medical Care, C. P. Anderson, M.D., Detroit; Evaluation of Prepaid Medical Services, B. C. Payne, M.D., Ann Arbor; Hospital Relations, R. V. Taylor, M.D., Chairman, Jackson; International Health, R. K. Nixon, M.D., Detroit; Medical Aspects of Organized Athletics, J. S. Feurig, M.D., East Lansing; Medicine and Religion, R. L. Rapport, M.D., Flint; Nursing, R. J. Mason, M.D., Birmingham; Rehabilitation, R. W. Pomeroy, M.D., Lansing; Relative Value Study, A. J. Neerken, M.D., Kalamazoo; Uniform Fee Schedule for Governmental Welfare Agencies, W. M. LeFevre, M.D., Muskegon; Veterans Affairs, William Bromme, M.D., Detroit; Workmen's Compensation, William Jend, Jr., M.D., Detroit.

Appointments to the MSMS House of Delegates Committee by Speaker James J. Lightbody, M.D., Detroit, will be reported in the February issue of MICHIGAN MEDICINE.

The MSMS Alcoholism and Drug Addiction Committee continued its practice of visiting various alcoholism programs across the state by holding its last meeting at the St. Luke's Hospital in Saginaw. The physicians toured the 12-bed alcoholism therapy unit there. Left to right are Jose J. Llinas, M.D., Jackson; C. W. Shipman, M.D., Midland; Chairman R. C. Bates, M.D., Lansing; G. F. Moench, M.D., Midland; H. H. Gay, M.D., Midland; H. A. Raskin, M.D., Detroit, and Donald J. Cady, who explained the St. Luke's program. (Saginaw News Photo)



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MICHIGAN STATE MEDICAL SOCIETY

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Michigan Mediscene

Jan. 21-22—Symposium on Blood—14th Annual—Wayne State University, McGregor Memorial Conference Center (International Symposium on the Physiology of Hemostasis and Thrombosis on Jan. 21; Scientific Session on Blood on Jan. 22).

Feb. 10—Conference-Diagnosis and Treatment of Radiation Accidents, Rackham Building, University of Michigan.

Feb. 26—Michigan Heart Association—Annual Heart Day, Sheraton Cadillac, Detroit.

March 9-10—20th Annual Postgraduate Clinic, Michigan Academy of General Practice, Sheraton-Cadillac Hotel.

Apr. 24—Michigan State Medical Assistants Society—9th Annual Educational Seminar, Bay City, Empire House.

MSMS Maternal Welfare Conference March 24-25

"We've arranged a truly outstanding program for the Fifth Annual MSMS Conference on Maternal and Perinatal Welfare in Flint, March 24-25."

That evaluation is given by W. W. Jack, M.D., Grand Rapids, Chairman of the MSMS Maternal Health Committee, the sponsoring organization for the Conference again. All members are invited.

Planning for this MSMS conference began many months ago to deal with vital topics and to obtain the best possible medical authorities. In addition to the Michigan experts, the program will include men from Philadelphia, California and Pittsburgh. The program will open with luncheon on Thursday, March 24, and conclude with the luncheon on Friday, March 25. The meetings will be at the Pick-Durant Hotel, where lodging is available.

Dr. Jack

Topics will include "The Respiratory Distress Syndrome," "Genetic Counseling for the Practicing Physician," "Syndromes in the Nursery—A Photographic Display," "Serologic Study of the Rubello: Incidence and Immunity," and others.

The speakers will include T. N. Evans, M.D., Professor and Chairman of Obstetrics and Gynecology, Wayne State University School of Medicine; James L. Wilson, M.D., Professor of Pediatrics and Communicable Diseases and Chairman of Department of Pediatrics and Communicable Diseases, University of Michigan Medical Center;

James B. Arey, M.D., Professor of Pathology, Temple University; David Treat, Ph.D., Sunnyvale, California, Family Education Consultant; James V. Neel, M.D., Professor of Human Genetics, Chairman of Department of Human Genetics, and Professor of Internal Medicine, University of Michigan Medical Center;

Otto C. Phillips, M.D., Pittsburgh, Chairman, Maternal Welfare Committee of the American Society of Anesthesiologists; Paul V. Woolley, M.D., Professor and Chairman, Department of Pediatrics, Wayne State University School of Medicine; Pediatrician-in-Chief, Children's Hospital of Michigan; Gordon C. Brown, Sc.D., Professor, Department of Epidemiology, School of Public Health, The University of Michigan.

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Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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Abstract of MSMS Council Action

Meeting of November 3, 1965

APPOINTMENTS

Ross V. Taylor, M.D., Jackson, was appointed MSMS representative to the Michigan Department o Public Health ad hoc Committee on Revision and Draft of Rules and Minimum Standards for Hospitals.

J. J. Llinas, M.D., of Jackson, was appointed MSMS representative to the National Conference on Community Mental Health Problems scheduled for December in Chicago.

RECOMMENDATIONS ON PSYCHIATRIC SERVICES FOR CHILDREN

The Council approved a statement entitled "Recommendations on Psychiatric Services for Children," submitted by the Committee on Mental Health. MSMS members will receive information soon regarding thi statement.

REPORT OF MICHIGAN MEDICAL SERVICE

Mr. Albert Kaufman, Director of Public Relations, Michigan Medical Service, reported for President Si ney Adler, M.D., regarding the present status of MMS in the National Association of Blue Shield Plans; th implementation of Medicare; and the appointment of Mr. John McCabe as Executive Director of Michiga Medical Service.

DATES AND PLACES OF FUTURE MSMS ANNUAL SESSIONS

Pending report of the House of Delegates' Committee to Review Change in Date of MSMS Annua Session, the following schedule was approved: Grand Rapids—9/25-30/66; Grand Rapids—9/24-29/67; Detro —9/22-27/68; and, Detroit—9/28-10/3/69.

COUNCIL'S COMMITTEE ON RELATIVE VALUE STUDY DISBANDED

The activities of The Council's Committee on Relative Value Study were turned over to the new House o Delegates' Committee on Relative Value Conversion Factor.

REPORTS OF STANDING COMMITTEES OF THE COUNCIL

Recommendations of the FINANCE COMMITTEE concerning accounting and budgetary procedures, an MSMS dues billing, were accepted by The Council.

The PUBLICATION COMMITTEE presented a report from Scientific Editor C. J. Tupper, M.D.; approve placing scientifically-oriented advertising between scientific articles in *Michigan Medicine;* received recommendations concerning the distribution of the MSMS history book prepared by Wm. J. Stapleton, Jr., M.D., an recommended that The Council create a Committee on Michigan Medical History.

The Council approved the Committee's recommendation that MSMS cosponsor in 1966 a Conference o Medical Writing, with the Michigan Tuberculosis and Respiratory Disease Association, the MSU School of Journalism, the MSU College of Human Medicine, and other possible cooperating groups.

The COUNTY SOCIETIES COMMITTEE reported on its study of hospital restrictions on general practitioners and that the Committee was seeking information from the Joint Commission on Accreditation of Ho pitals; recommended that The Council reaffirm and emphasize its policy supporting separate billing for th professional aspects of radiology, anesthesiology, pathology and physiatry services. The Committee reviewe and discussed revised proposed Rules and Minimum Standards for Hospitals, as developed by the Michiga Department of Public Health. The County Societies Committee recommended that The Council discuss an take a position regarding the administration of Title 19 of the Social Security Act, which designates th Governor as "administrator." The Council adopted a motion stating that the Michigan State Medical Societ supports the Michigan Department of Public Health in the management of Title 19. The recommendations o the County Societies Committee were accepted by The Council.

The EDUCATION LIAISON COMMITTEE reviewed the role of the State Board of Education in medic education, the Coggeshall Report on "Planning for Medical Progress Through Education," family practic possible osteopathic college, the Michigan Community Health Services Study, class size at Michigan's tw medical schools, new developments at MSU College of Human Medicine, and relationships between nursin education and medical education.

JUDICIAL COMMISSION NOMINATIONS

Secretary D. Bruce Wiley, M.D., announced the list of Judicial Commission nominees.

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ORIGINAL
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ARTICLE

The Effects Of Intra-Venous Diazoxide, A Non-Diuretic Thiazide, Upon Blood Pressure, Electrolyte, And Uric Acid Excretion

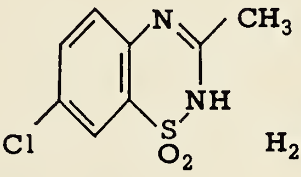
George R. Thompson, M.D.
Robert W. Anderson, M.D.
Lynne M. Ballantyne

Diazoxide is a benzothiadiazine chemically similar to chlorothiazide (**Figure 1**), differing mainly by he absence of a free sulfamyl group.

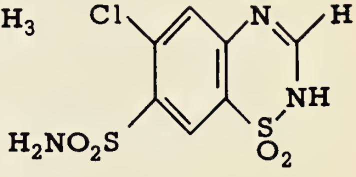
Pharmacologically, however, it is quite dissimilar. The oral administration of 200 to 400 milligrams of diazoxide has been shown to produce an antidiuresis, decreasing sodium, potassium, chloride, nd free water excretion, while lowering blood pressure.[1,2] Hyperglycemia[3] and hyperuricemia[4] have been reported following prolonged oral use. When diazoxide is given by rapid intravenous njection it produces prompt hypotension, lasting several hours.[5] It has been recommended for the treatment of hypertensive crisis,[6] particularly in the presence of renal disease. Thus, in view of the potential clinical usefulness of intravenous diazoxide, it was felt further documentation of the effects on blood pressure and electrolyte excretion were justified. Also, due to the similarity and dissimilarity to chlorothiazide noted above, the effect on uric acid excretion is of interest and affords an opportunity to further study the mechanisms of renal tubular handling of uric acid.

METHOD

Eleven volunteer patients were studied immediately prior to their discharge from the hospital. All were in relatively good health. A control three-hour urine specimen was collected, following which the drug was given by rapid intravenous injection over a ten-second period. Two subsequent three-hour urine collections were obtained. Blood samples were obtained at the beginning and end of each urine collection. Blood pressure was monitored throughout the study.



Diazoxide



Chlorothiazide

Figure 1. The chemical structure of diazoxide and chlorothiazide.

Nine subjects received 300 milligrams of intravenous diazoxide,* though on one subject only blood pressure data was used, due to inaccurate urine collections. One subject received 600 milligrams of intravenous diazoxide, and another 300 milligrams of intravenous diazoxide plus 1500 milligrams of oral probenecid. The effects of 300 milligrams of intravenous chlorothiazide were also studied in four of these subjects. The blood pressure response of five patients treated with intravenous diazoxide for acute hypertensive crisis was also studied.

Serum and urine were assayed for uric acid by an enzymatic method.[7] Creatinine was measured by a modification of the Jaffe reaction. Serum and urine sodium, potassium, and chloride concentration were determined by emission spectrophotometry, using a "Technicon Auto-Analyzer."** Urine pH was measured on a Beckman pH meter, and titratable acidity was determined by titration with

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George R. Thompson, M.D., is Assistant Professor of Internal Medicine, University of Michigan, and Director, Rheumatology Section, Wayne County General Hospital.

Robert W. Anderson, M.D., is Associate Physician, Hypertension Division, Henry Ford Hospital; formerly Chief Resident, Department of Medicine, Wayne County General Hospital.

This work was supported by a grant from the Michigan Chapter of the Arthritis Foundation.

*Diazoxide (Hyperstat, Schering) was obtained through the courtesy of Dr. Edward F. McMahon, Schering Corporation, Bloomfield, New Jersey.

**These electrolyte determinations were done in the clinical laboratories of the Wayne County General Hospital, through the courtesy of Dr. Frank R. Ellis.

0.1 N NaOH to pH 8.6, using phenolphthalein as indicator, results being expressed as milliequivalents of H^+ per 100 milliliters of urine.

RESULTS

Blood Pressure Response:

Figure 2 depicts the mean fall in blood pressure during the first five minutes, 30 minutes, three hours, and six hours after administration of diazoxide or chlorothiazide. Among the control subjects two had an elevated blood pressure above 150/90. Diazoxide produced a prompt decrease in systolic and diastolic blood pressure in both the control subjects and the hypertensive patients. Chlorothiazide produced only a very gradual decline in blood pressure, of less magnitude.

Among the control subjects (**Table I**) there was a mean fall of 34 mm in systolic pressure, and 25 mm in diastolic pressure, during the first five minutes; and 28 and 18 mm, respectively, during the first half hour after drug administration. At the end of six hours there was still some diminution of blood pressure. Among the hypertensive patients treated there was a somewhat greater fall in both systolic and diastolic pressures during these same intervals of time. The 600 milligram dose of diazoxide did not produce a greater fall in blood pressure than did the 300 milligram dose, though this dose was studied in only one subject. This individual developed a tachycardia of 120 beats per minute, and experienced very little drop in systolic blood pressure, but had a fall of 24 mm in diastolic pressure during the first five minutes and an 18 mm lowering during the first 30 minutes after drug administration. The subject receiving probenecid had similar changes in blood pressure.

Considering the subjects individually, the most consistent response appeared to be in diastolic pressure. Further, comparison of the results among the control and hypertensive patients suggested that the higher the initial blood pressure, the greater the reduction produced by diazoxide.

The clinical usefulness of diazoxide is demonstrated in the following case:

O.McW. (WCGH #154182) (**Figure 3**) is a 44-year-old Negro man who presented at the emergency room with uncontrollable epistaxis. Blood pressure was 260/160, and cardiomegaly was present. Hypertension had been previously undiagnosed. Renal impairment was indicated by a blood urea nitrogen of 65 mg per 100 ml and a serum creatinine of 2.4 mg per 100 ml. He was treated with nasal packs, and given digitalis and whole blood. As the blood pressure remained elevated, and it appeared he was entering hypertensive crisis, 300 milligrams of diazoxide was given intravenously, over a ten-second period, resulting in a rapid and marked reduction in blood pressure (**Figure 3**). Subsequently his blood pressure was well controlled on hydrochlorothiazide and alphamethyl DOPA.

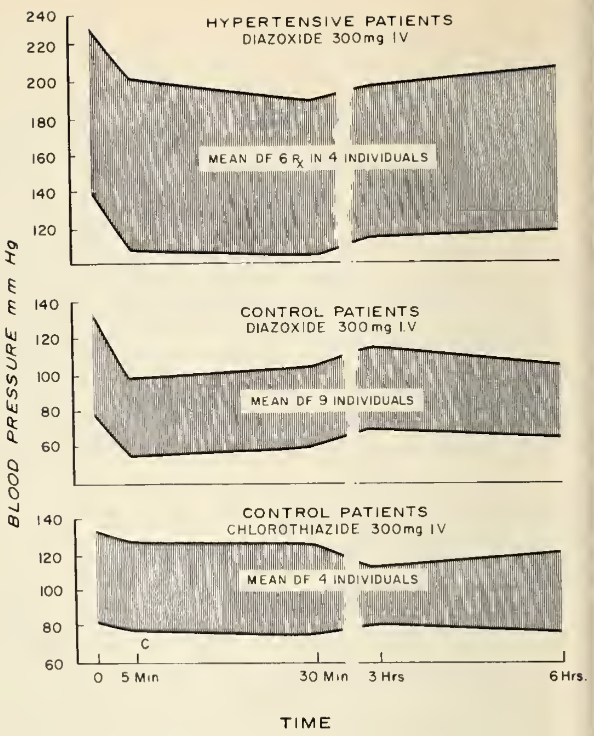

Figure 2. The effect of intravenous diazoxide and chlorothiazide upon blood pressure. This is expressed as the mean value of determinations in several individuals. The upper line in each graph represents systolic blood pressure, and the lower diastolic.

	CONTROL SUBJECTS		HYPERTENSIVE PATIENTS	
	Systolic	Diastolic	Systolic	Diastolic
First 5 minutes	34 mm.	25 mm.	49 mm.	29 mm.
First 30 minutes	28 mm.	18 mm.	59 mm.	31 mm.
Six hours	28 mm.	12 mm.	42 mm.	22 mm.

Fall in Blood Pressure in Millimeters of Mercury

Following Intravenous Diazoxide

Table I. Comparison of the mean changes in blood pressure produced by intravenous diazoxide in normal control subjects and hypertensive patients.

Electrolyte Excretion:

The effect of intravenous diazoxide on electrolyte excretion was studied in the ten control subjects. **Figure 4** depicts the changes in sodium excretion.

Diazoxide produced a mean decrease in sodium excretion in the eight subjects given 300 milligrams, and also in the subject given 600 milligrams of the drug. This effect was unaltered by the concurrent administration of probenecid. Chlorothiazide produced a prompt sodium diuresis. It is of interest in comparing these two drugs to note that the greatest effect of diazoxide was in the second three-hour period, while that of chlorothiazide was in the first hree hours after the drug was given. Both drugs were given by rapid, ten-second, intravenous injecion.

Potassium excretion was similarly affected, being ncreased by chlorothiazide and decreased by diazoxide. There is evidence that potassium is excreted by active tubular secretion, and that there is a eciprocal relation with the excretion of hydrogen on.[8] We found that the urine titratable acidity was decreased by chlorothiazide, and increased by diazoxide. Similarly, urine pH rose after chlorothiazide administration, and fell after diazoxide. These data would support a relationship between hydrogen on and potassium ion excretion. Chloride excretion was also depressed by diazoxide, though to a lesser degree.

Uric Acid Excretion:

Uric acid excretion was measured in the ten control subjects. Considering 6.0 mg per 100 ml as the upper limit for normal serum uric acid, two individuals were hyperuricemic. One had had acute gouty arthritis, but no tophi were demonstrable.

Diazoxide consistently produced a reduction in urinary uric acid (**Figure** 5) with both the 300 milligram and 600 milligram doses. This effect was completely blocked by the concomitant administration of probenecid, a potent uricosuric agent. Chlorothiazide, given intravenously, produced a urate diuresis, supporting the findings of others.[9,10] Oral chlorothiazide, however, has been shown to regularly produce a decreased urate excretion.[10]

Creatinine clearance was variably affected during the study. However, the urate clearance: creatinine clearance ratio was decreased by diazoxide (**Figure** 6), but this effeet was blocked by probenecid. The ratio was increased by intravenous chlorothiazide. These changes in the urate clearance: creatinine clearance ratio demonstrate that the changes in urate excretion are not merely a reflection of a decreased or increased glomerular filtration rate, in which case the ratio would remain unchanged, but instead represent an absolute effect on the renal handling of uric acid.

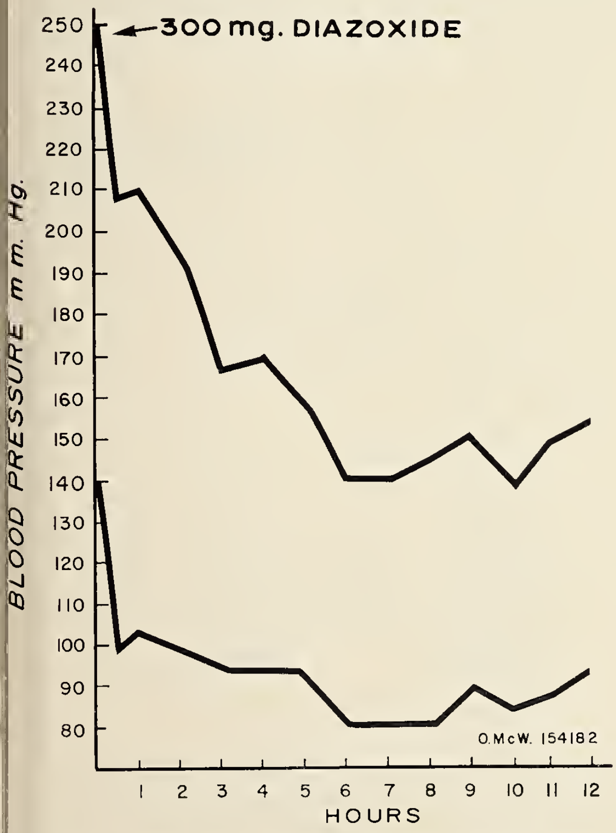

Figure 3. The blood pressure response to intravenous diazoxide in a 44-year-old man with acute hypertension.

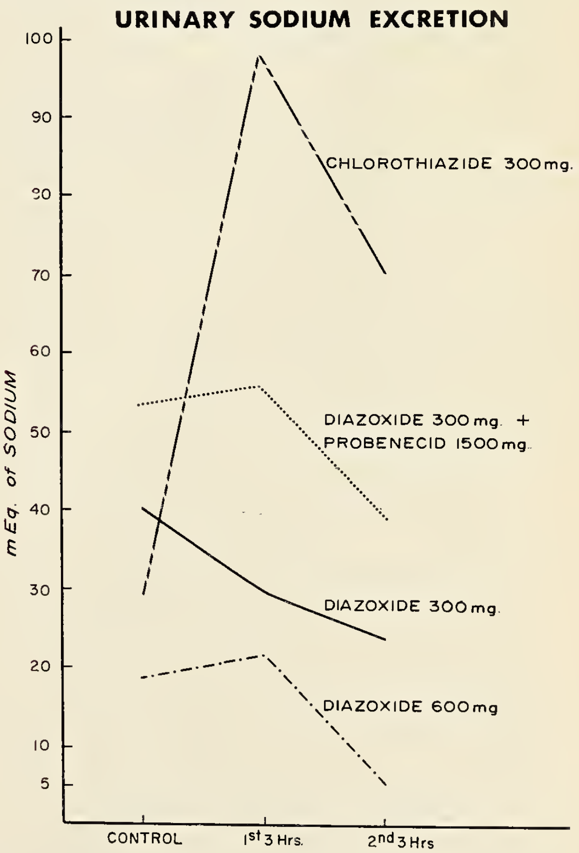

Figure 4. Sodium excretion (in milliequivalents) during a control three-hour period, and two subsequent three-hour periods after the intravenous administration of diazoxide or chlorothiazide.

DISCUSSION

The effects of diazoxide and chlorothiazide on urate excretion are of considerable interest. Animal experiments, using the stop-flow technique, indicate that the canine kidney (and presumably also the human kidney) excretes uric acid by a process of filtration, reabsorption, and subsequent active tubular secretion (**Figure 7**).[11-14] Uric acid is completely filtered at the glomerulus. It is now thought to be completely, or nearly completely, reabsorbed in the proximal convoluted tubule. Some experiments suggest also active tubular secretion of uric acid in the proximal convoluted tubule.[11] Further active secretion has been demonstrated in the distal convoluted tubule,[13] with the uric acid appearing in the urine being the result of these secretory processes.

On this basis the observed changes in urate excretion may be explained, and thus render further support for these mechanisms being active in the human kidney. By blocking tubular secretion of uric acid, a diminished urinary excretion would occur, explaining the effects of diazoxide and oral chlorothiazide. If, however, tubular reabsorption were also blocked, to an extent greater than tubular secretion of uric acid, then uricosuria would occur.

It is postulated that the high concentration of chlorothiazide following intravenous injection results in blocking both urate secretion and reabsorption, while the lower concentration following oral administration blocks only secretion. This would correspond to the paradoxical decrease in urate excretion by small doses of probenecid, whereas the customary doses produce marked uricosuria. Diazoxide would seem to differ from chlorothiazide as neither the usual therapeutic dose, or twice that dose, produced uricosuria. Hydrochlorothiazide would seem to occupy an intermediate position between chlorothiazide and diazoxide regarding urate excretion, as intravenous hydrochlorothiazide has been shown to produce uricosuria in some subjects, no effect in others, and decreased uric acid excretion in still others.[15]

The effects of diazoxide on electrolyte excretion are more difficult to explain. There is evidence suggesting that potassium is excreted by active

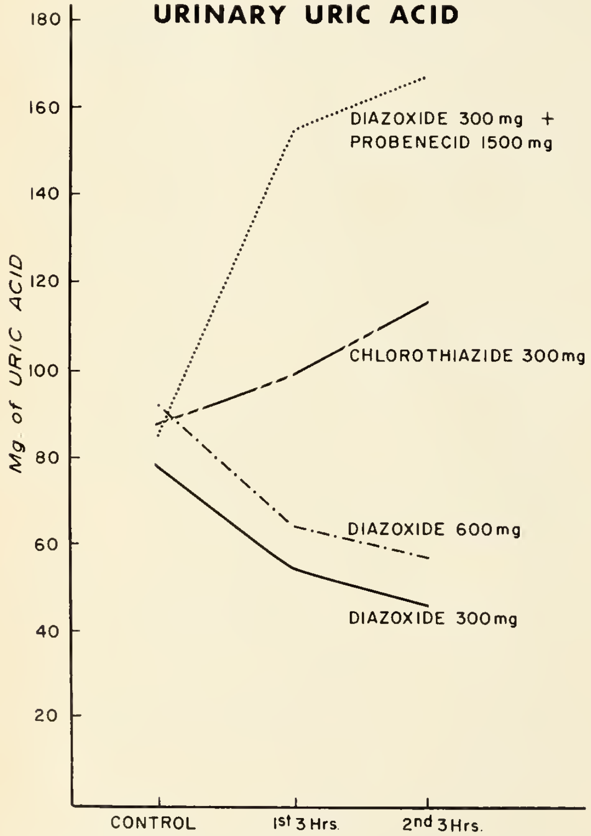

Figure 5. Uric acid excretion (in milligrams) during a three-hour control period, and two subsequent three-hour periods after the administration of intravenous diazoxide or chlorothiazide. Probenecid was given orally at the time the intravenous diazoxide was administered.

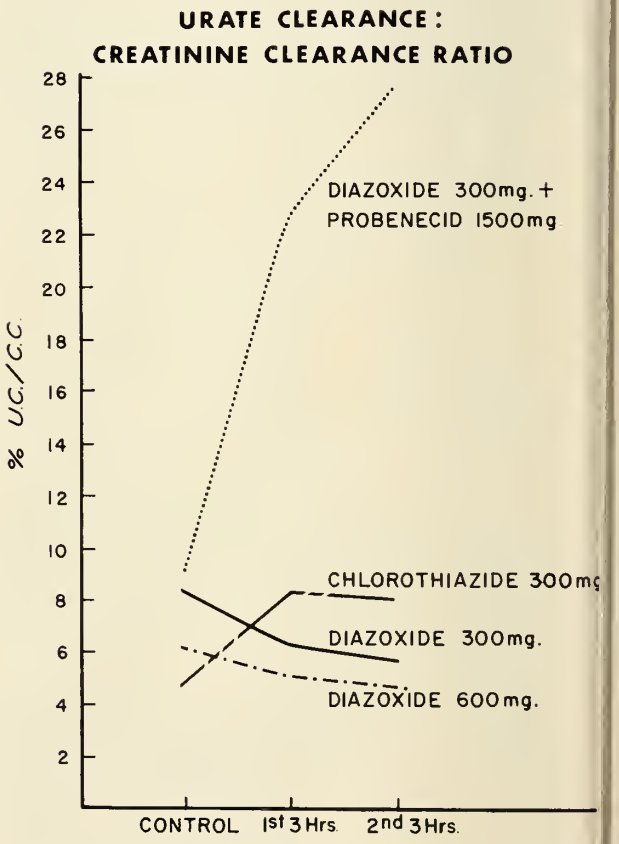

Figure 6. Urate excretion expressed as the urat clearance: creatinine clearance ratio. This rati negates changes in uric acid excretion produced b changes in the glomerular filtration rate.

tubular secretion.[8] It is attractive to postulate that potassium excretion is decreased by inhibition of tubular secretion by diazoxide. However, the direction of tubular transport of sodium is primarily reabsorption, and drugs generally block enzymatic processes and do not enhance them. It has been suggested that the decrease in free water excretion by diazoxide is mediated through anti-diuretic hormone,[16] and drugs have been reported that inhibit the destruction of anti-diuretic hormone.[17] However, presently the exact mechanism whereby diazoxide exerts its effects on electrolyte and water excretion is unclear.

The prompt hypotensive effect of intravenous diazoxide would indicate a direct effect on vascular tone, as other studies have shown that cardiac output is unchanged or increased.[5] The natriuretic effect of the diuretic thiazides has been considered as an explanation for their hypotensive properties. However, the hypotensive effect of diazoxide, which is a non-diuretic thiazide, would suggest that more likely thiazides lower blood pressure by directly affecting the blood vessel musculature.[18]

SUMMARY

The effects of intravenous diazoxide on blood pressure was measured in eleven control subjects, and electrolyte and uric acid excretion was studied in ten. These results were compared with intravenous chlorothiazide. The blood pressure response to intravenous diazoxide of five patients with acute hypertension is also reported.

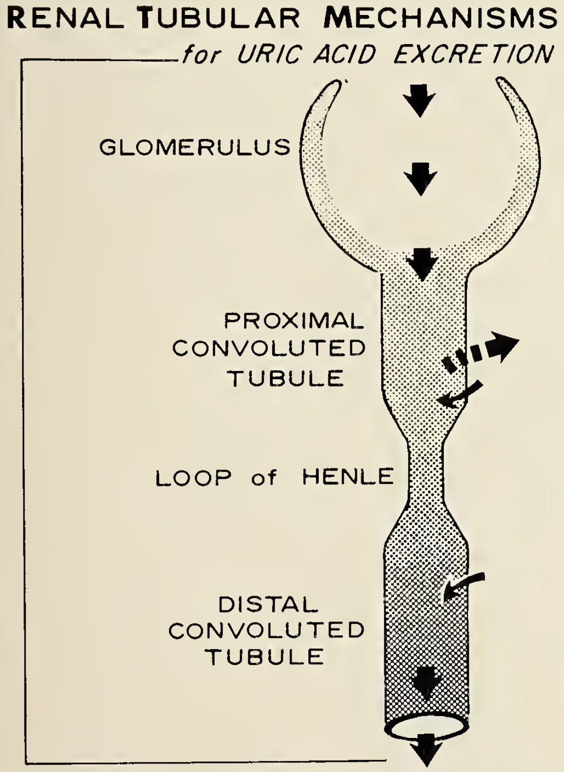

Figure 7. Schematic diagram of urate excretion. Uric acid is completely filtered at the glomerulus, reabsorbed in proximal tubule, and actively secreted by the proximal and distal convoluted tubules.

DIAZOXIDE		CHLOROTHIAZIDE
	Blood Pressure	
Immediate Hypotension		Delayed Hypotension
Short Duration		Longer Duration
Decreased	Sodium Excretion	Increased
Decreased	Potassium Excretion	Increased
Decreased	Chloride Excretion	Increased
Increased	Urine Acidity	Decreased
Decreased	Uric Acid Excretion	i.v. - Increased oral - Decreased

Table II. Summary, comparing effects of intravenous diazoxide and chlorothiazide.

Intravenous diazoxide (**Table II**) produced immediate hypotension of relatively short duration, contrasted to chlorothiazide which caused a delayed effect of longer duration. Sodium, potassium, and chloride ion excretion was decreased; hydrogen ion increased; and uric acid excretion decreased by diazoxide. Intravenous chlorothiazide produced the opposite effect. For short-term, emergency use, the hypotensive properties of diazoxide appear to make this drug a useful adjunct to the clinician's armamentarium.

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(Continued on Page 24)

ORIGINAL
SCIENTIFIC
ARTICLE

Acute Hemolytic Anemia Complicating Infectious Mononucleosis

Feridun Gurol, M.D.

The occurrence of acquired anemia during the course of infectious mononucleosis is a rare and unusual complication. Since Dameshek[1] reported the first case of acute hemolytic anemia associated with infectious mononucleosis, 27 similar cases have been described in English literature.

The present case is one of infectious mononucleosis complicated by severe hemolytic anemia.

CASE REPORT

A 23-year-old white male was hospitalized with symptoms of anorexia, malaise, fatigability, chilly sensation, mild sore throat, shortness of breath, headache and upper abdominal distress of three days' duration. Three days prior to admission he was seen at his dispensary for these symptoms and was found to have a fever of 101°F, and the physical examination was said to be normal, except for an injected throat. He was given an unknown quantity of APC's with the diagnosis of common cold. Because of the worsening of the symptoms he was hospitalized.

Systemic review and family history were negative; he had pneumonia in 1960 and had had mild bronchial asthma since childhood. He had been on Tedral and Chlortrimeton periodically for asthma.

Physical Examination: Height 6 feet 2 inches; weight 240 lbs; Temperature 100°F; Blood pressure 145/80. The patient was a well-developed, rather obese male with moderate pallor and yellow sclerae. The liver was palpable two finger-breadths below the costal margin, and the tip of the spleen was palpable on deep inspiration. The pharyngeal mucosa was injected, but no plaques were noted. Shotty, non-tender lymph nodes were palpable in the posterior cervical chains.

Laboratory Results: A peripheral blood smear revealed marked anisocytosis, minimal poikilocytosis, moderate spherocytosis and polychromasia of the erythrocytes with 5 per cent normoblasts. The leukocyte count was 11,000 and the differential count showed 69 per cent lymphocytes, 29 per cent neutrophiles and 2 per cent monocytes. Platelets 137,000, hematocrit 25 per cent, hemoglobin 6.4 grams, red cell count 1,850,000 and reticulocyte count 5.8 per cent. Color indices: Mean Corpuscular Volume 94 cubic microns, Mean Corpuscular Hemoglobin 29 micromicrograms and Mean Corpuscular Hemoglobin Concentration 30 per cent.

A bone marrow smear revealed marked erythroid hyperplasia with a normal progression of maturation and no evidence of nuclearcytoplasmic dyssynchrony. The white cell series were sparse. However, no abnormalities were noted. A test of red cells osmotic fragility revealed initial hemolysis at 0.69 per cent, and complete hemolysis at 0.21 per cent. (The control initial hemolysis was 0.45 per cent, complete hemolysis at 0.39 per cent). The heterophile agglutination test revealed initially a 1:1024 antibody titer. After absorption with guinea pig antigen the titer was 1:448 and after absorption with beef erythrocyte antigen there was no titer.

The Coombs test was positive. The cold agglutination was positive with a titer of 1:320. There was steady elevation of heterophile agglutination titer to 1:4096 at the end of the first week with guinea pig absorption of 1:896, but no absorption with a beef erythrocyte antigen. Free hemoglobin was present in urine and urobilin was found with a urine dilution to 1:256. The total bilirubin was 3.6 mg per cent (indirect 2.8 mg per cent, direct 0.8 per cent), total cholesterol 173 mg per cent, thymol turbidity 6.8 units, alkaline phosphatase 1.82 Sigma units, SGOT 34 units, SGPT 32 units, cephalin flocculation trace. Several blood cultures were negative, a serologic test for syphillis, bleeding and clotting times, and hemoglobin and protein electrophoresis were normal. No LE cells were present. The stool for occult blood was negative on several occasions.

The patient remained febrile (100-101°F) during the first week of hospitalization and complained of sore throat and extreme malaise. On the third hospital day, the hematocrit fell to 19 per cent and the patient initially was started on 200 mg of Hydrocortisone intravenously over a period of eight hours during the first 24 hours.

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Thereafter, Prednisone in the form of Meticorten vas started in an initial dose of 20 mg every six ours for the first five days. The dose of Prednisone vas tapered off gradually by 10 to 20 mg every five lays the following four and a half weeks and disontinued. On the tenth hospital day the hematorit was 30 per cent. By the twentieth hospital day he hematocrit was 45 per cent. By the thirtieth ospital day there was no laboratory evidence of emolysis, the spleen and the liver were not palpale, and the patient was afebrile and asymptomatic. he cold agglutination and Coombs tests became egative; however the heterophile agglutination remained elevated until the forty-fifth day of hositalization. When he was seen in Medieal Clinic, wo months after the onset of his illness, there was o chemical evidence of infectious mononucleosis r hemolytic anemia. He was carrying on normal uty.

COMMENT

In this case the onset of anemia was sudden with eticulocytosis, erythroid hyperplasia of the bone marrow and transient hemoglobinuria bearing out he impression that it was due to a hemolytic rocess. As far as could be determined, the hemolyc process appeared about two days after the onset f the underlying disease. It rapidly produced a evere anemia which required steroid administraon. The antibody in this case was a cold aglutinin. This type of cold antibody was described y Wintrobe[2] as occurring in the symptomatic acuired hemolytic anemias. The cold agglutinin eemed to be related to the hemolytic process in hat it disappeared as the anemia improved. Howver, the heterophile agglutination test was posive long after the cold agglutinin and Coombs tests ecame negative.

The recognition of atypical lymphocytes sugested the possibility that this might be a case of nfectious mononucleosis with severe hemolytic nemia and the strongly positive heterophile aglutination test confirmed this suspicion. The emolytic anemia seemed in all likelihood to have eveloped as a direct complication of the infectious mononucleosis. However, one cannot dismiss comletely the possibility that the drugs might have played some role in producing the hemolytic process. The only drug which may be incriminated in causing hemolytic anemia is APCs. Phenacetin has been known to produce hemolytic process if a sufficiently large dose is given.

DISCUSSION

Severe anemia is an unusual complication of infectious mononucleosis. In large series of cases anemia was rarely found.[3] Thus far 27 cases of infectious mononucleosis with an acquired hemolytic anemia have been reported in English literature.[4-31] It is likely that the greater number of patients with infectious mononucleosis are not hospitalized and the cases with a mild degree of hemolytic anemia probably are missed.

On the basis of evidence at hand, it seems fair to assume that hemolytic antibodies in several of the reported cases were responsible for the hemolytic process. Seven of ten patients had a positive Coombs test and ten of 14 patients had elevated cold hemagglutinins.[21] In some cases no evidence for such antibodies was found.[18] The hemolytic process usually appeared quite early and the onset was sudden and rather dramatic. The degree of anemia and duration varied from patient to patient.

Jaundice was present from a mild to moderate degree in all the cases. Splenomegaly was present in most, and a very large spleen in one case was probably due to Cooley's anemia.[18] The liver was slightly enlarged in about half of the cases. The cervical lymphnodes were enlarged in most cases and in many there was generalized lymphadenopathy. Four of the reported patients had gross hemoglobinuria.[5,6,13,16] Only three cases of hereditary spherocytosis in association with infectious mononucleosis have been reported.[21,30,31]

A patient was described by Mengel[22] who developed megaloblastic bone marrow arrest during an acute episode of hemolysis associated with infectious mononucleosis. The complication of autoimmune hemolytic anemia with thrombocytopenia has been reported by Smith.[23]

Since the hemolytic process is part of a self-limited disease, therapy directed toward the hemolysis is probably not necessary in most cases. However, the degree of hemolysis or its continued progression may warrant blood transfusion, and possible steroid therapy. Seven patients recovered with the administration of steroids.[13,15,20,22,27,32,33] Splenectomy with prompt recovery has been reported.[8,18,21,31]

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SUMMARY

1. One case of infectious mononucleosis complicated by acute hemolytic anemia is presented.

2. Acute hemolytic anemia is a very rare complication of infectious mononucleosis. Only 27

cases have been reported in English literature.

3. The patient recovered probably as the result of steroid administration.

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(Continued from Page 21)

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ORIGINAL SCIENTIFIC ARTICLE

Identification of human skeletons or skeletal parts requires specialized aining in many areas. For this reason a group of health science spe-alists, interested in problems of identifications of human skeletal aterial, has been established at the University of Michigan. The core oup consists of an anatomist, medico-legal pathologist, oral surgeon, rtial denture prosthodontist, and a radiologist.

The case presented represents the close working relationship between o of the team members. Together they were able to identify a missing rson from analysis of a human skeleton and a chest x-ray of the spected missing person.

Identification Of Human Remains

F. Huelke, Ph.D.
F. Lalli, M.D.

Routinely, for the past several years, members of : Michigan State Police Crime Laboratory have juested our assistance in identification of human eletons and body parts.

Such material is delivered to one of us (D.F.H.) r determination of age, sex, race, body height, and y other information which might be gleaned om the specimen in order to establish the identi-ation of the individual and the possible cause of ath. Whenever necessary the help of other pro-ssionals in the various health science specialties s been requested.

* * *

THUS, WE HAVE established a core group of erested specialists including an anatomist, dico-legal pathologist, oral surgeon, partial den-re prosthodontist, and a radiologist. Others have licated an interest in this type of work and will called upon when needed. The following case emplifies the type of cooperation between two of e members of this team.

The material in this case was a near complete man skeleton. From the appearance of the bones, e specimen had not been buried in the ground. ly a few distal phalanges of the fingers and the ht calcaneus were missing. After the bones were otographed in their proper anatomical position, detailed study of each bone was made. No evi-nce of recent antemortem trauma was found.

The skeleton was that of an adult male, and measurements of the long bones indicated that the individual was 5′ 5″-5′ 7″ in height. Skull features indicated that the individual may have been of Mexican extraction. The age was estimated at 30 to 35 years. However, the age of adult skeletons is extremely difficult to establish due to lack of good aging criteria. Several well-developed exostoses were found on the jugular notch of the manubrium of the sternum.

In that the police had only one missing person report from the area where the skeleton was found, they thought this skeleton and the missing person might be one and the same individual. With the unusual finding of suprasternal exostoses it was suggested that a chest x-ray of the missing person would aid in the skeletal identification and no further study of the skeleton was made until a search for an x-ray could be undertaken.

* * *

FORTUNATELY, THE missing person had a routine chest film taken in another state several years before his disappearance. This x-ray was obtained by the police following an extensive investigation which lasted six months. This film along with the skeleton was taken to the radiologist. Examination of the film showed that the top of the manubrium was completely obscured by the verte-

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brae and could not be studied for comparison with the bone specimen. However, from study of the chest film the radiologist noted a healed fracture of the left second rib (Figure 1). The fracture was located approximately 4 cm from the costochondral junction.

The second rib of the skeleton was identified and it too had been fractured in the same location. X-rays were taken of this rib (Figure 2). When compared with the chest film, both ribs were identical. No other rib fractures were noted in the chest film, or on the skeleton. Because of the unusual position of the fracture of only this one rib it was concluded that there was sufficient evidence for a positive identification.

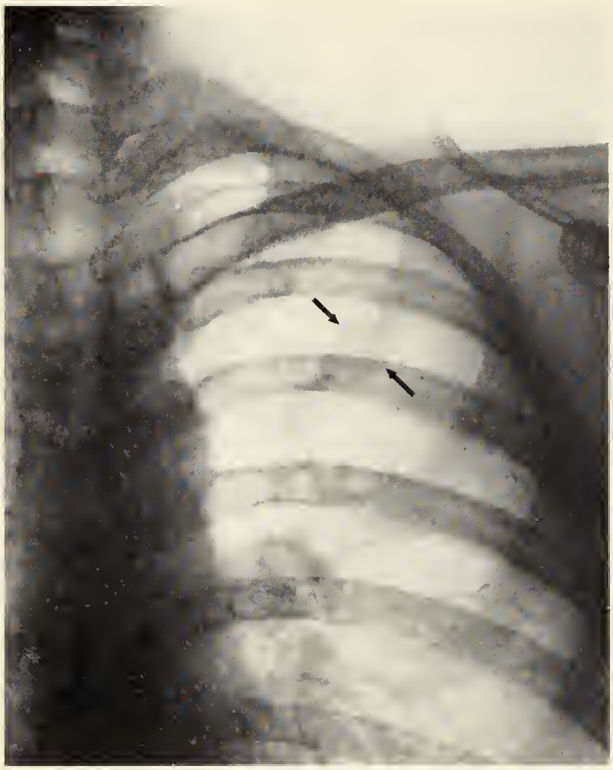
Figure 1. The upper left portion of missing person's chest x-ray. Note healed fracture of second rib (arrows).

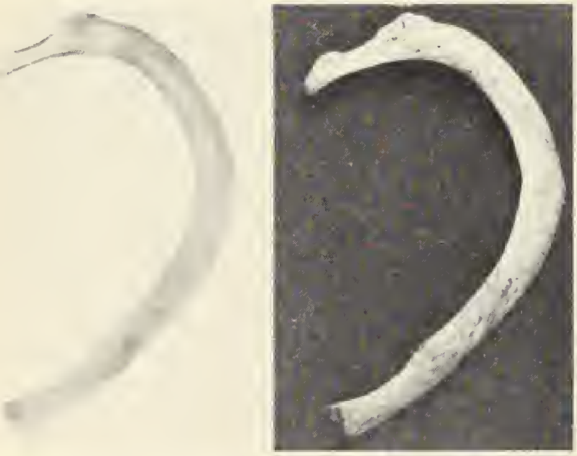
Figure 2. The left second rib: roentgenogram (left) and photograph (right).

The results of our findings are compared below with the description of the missing individual:

Skeletal Identification	Missing Person's Description
Age: 30-35 years	42 years
Sex: Male—Mexican (?)	Male—Mexican
Height: 5′5″-5′7″	5′6″
Weight: 150 pounds	145 pounds
Pathology: Healed fracture of left second rib near costochondral junction; suprasternal exotoses; healed fractures of nasal bones.	Healed fracture of second rib near costochondral junction.
Teeth: Full upper denture with gold central incisors.	Two gold teeth “i front”

This case is presented to describe the type of information that can be obtained from skeletal material. Greater difficulty in assessing age, sex, race body height, etc., is encountered when only a few bones are available. Therefore, it is imperative that all bones be recovered with utmost care Often these bones are quite brittle and rough handling will produce fractures which makes identification all the more difficult.

Such recovery efforts are best left to the experienced personnel of the Michigan State Police Crime Laboratory or others trained in this work As has been previously reported (Huelke an Burdi, 1964) even the hand, wrist, foot, and ankl bones are important in some cases. For thos interested in skeletal identification, the outstanding book by Krogman (1962) should be studied.

This case exemplifies the availability of highl qualified members of various health science specialties at The University of Michigan who ar interested in problems of human skeletal identification.

ACKNOWLEDGEMENTS

For their cooperation and assistance in this an similar cases, we wish to thank the members o the Michigan State Police Crime Laboratory.

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Psychological Principles In the Management of the Physically Ill Adolescent

ORIGINAL
SCIENTIFIC
ARTICLE

orris Weiss, M.D.

First, it would be well to review briefly the rmal psychological development in adolescence d to discuss its phase-related problems. Generally eaking, the emotional growth and problems of the lolescent are due to the endocrine changes of bescence and the social pressures to which he exposed.[1] For the sake of clarity this period can broken down into three parts: Early, middle and te adolescence.

Early adolescence is that time in which the child ust adapt to his own bodily changes. During this ase the child is concerned with his body strange- ss, with masturbation and other sexual conflicts.

During **middle adolescence** the child struggles r his independence, to achieve social and love re- tionships outside the family. Here his need to be dependent is complicated by his need to remain mewhat dependent as well.

During **late adolescence** he struggles to establish s identity and his role within the framework of ciety. He will choose his life's work and eventu- ly his mate.

It is inevitable that during this period the normal lolescent must become "upset." The increase his inner drives and the greater social demands aced upon him temporarily overwhelm him and ing into play a variety of neurotic-like devices de- gned to maintain his psychological homeostasis.[2]

HE NORMAL SOMATIC ROBLEMS OF THE AGE

Just as an adult patient frequently appears in his ysician's office with a functional problem ex- essed in somatic terms, so can the adolescent come to the pediatrician on the same basis. Most of these "normal somatic problems" are due to the young patient's concern with his rapidly changing body.

In such cases, the role of the doctor in orienting the adolescent to what is occurring inside him and normalizing the phenomenon for him is probably all that is needed in most cases.

1. Rapid growth occurs when the sex organs function and the secondary sex characteristics begin. Considering the growth pattern according to the individual's own curve and not as an average is important. Both the rapid and the slow growers feel different as compared to their peers. Reassurance by the pediatrician is in order that he is following his own growth line of development.

EXAMPLE: A 13-year-old boy who was precociously bright and advanced in school was worried about his short stature. Also, he wondered why he was the only boy in his gym class without pubic hair. His father told him not to worry, that everyone was short in the family. The mother shared her son's concern and expressed the thought he needed hormonal injections.

Consultation with the pediatrician followed. He did a careful physical study of the boy including some metabolic measurements and x-rays to determine bone age. Noting the boy's intellectual curiosity, the doctor explained the rationale of his work-up. He plotted his growth curve on the chart pointing out how the boy fell into one of the normal lower percentile groups. He also explained the apparent delay in sexual characteristics as a variation of normal development. The adolescent then told his physician that he didn't feel his father appreciated his worrying and couldn't discuss it with him. He felt relieved. The doctor recognized the mother's concern and took time to orient her as well.

2. A feeling of tiredness and fatigue is commonly seen. Perhaps the adolescent is more aware of his inner sensations or he may actually have some mild malnutrition. His rapidly growing body is

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This paper was delivered at the 1965 Annual Clinic Days onsored by Children's Hospital, Detroit, and the Pediatric epartment of Wayne State University School of Medicine.

under more strain and his physiological reserve is depleted. The doctor's role here is to assure the adolescent (after significant pathology is ruled out) that it is normal to get tired, that it does not mean something is wrong with him. He can feel it is not shameful to rest and show some moderation in activity. Here, too, the parents need to know their son or daughter is simply not "lazy."

3. Related to the above is a normal hypochondriasis of this period. The adolescent's body is unfamiliar to him as it changes. He becomes concerned with physical symptoms. An example is acne.[3] His tendency to focus upon his body, his own personalized thinking about the meaning of this skin disorder may make him anxious. Sometimes acne is connected in the minds of youngsters with sexual practices, such as masturbation. They equate the sexual "dirt" with the epidermal "dirt."

This illustrates how the phantasies woven around the somatic problem may be the most important thing for the physician to deal with in attempting to relieve the patient's anxiety. For instance, as the doctor explains to the adolescent why acne really develops in this period, he may realize that what he is doing is dispelling unrealistic sexual guilt about the condition.

4. Secondary sex changes can be regarded anxiously. Acceleration or lag might in itself concern the boy or girl. In boys temporary breast development may mobilize fear of effeminacy. An undescended testis can suddenly be disturbing.

EXAMPLE: An adult in psychotherapy remembered that as a 13-year-old boy he had an undescended testis and was taken to several doctors by his mother. He became more fearful when one of the physicians told his mother that an operation might be needed if hormonal injections would not bring the testis down into the scrotum. Since no one explained to the boy what was meant, he assumed that the operation meant the removal of one or both of his testes. He also worried about the fact that his other testis was too large, whether this meant he could not be as strong or as masculine as the other boys. He reflected that if one of the doctors had introduced private discussion with him, he would have felt free to ask some of the questions which troubled him.

Though it may appear that the present-day adolescent is sophisticated and knowledgeable regarding sexual matters, it is surprising that his information is sometimes superficial, incomplete and distorted. The pediatrician may here serve an important function in using a routine office visit in giving necessary sex orientation. Sometimes the doctor is a more preferable person than the parent because of the nature of the child's attachment t the family.

THE MEANING OF PHYSICAL ILLNESS TO THE ADOLESCENT

Adolescents may somatize their problems. Th adolescent who is anxious about meeting the normative tasks of this phase may unconsciously choos to have physical symptoms. Somatic complaint are more real and more acceptable to him and t others than psychological discomfort.

How an adolescent considers his illness, particularly a chronic one, is based on his past personalit development, his own previous experiences i reference to his illness, the reaction of his family particularly the parents, to him and to his illnes Hence no observer can substitute for the docto who has a continued contact with his adolescen patient and his family throughout the years.

In spite of the need to stress the individual' response to his illness, let us consider the genera meanings of somatic illness to the adolescent:

1. He may feel different by virtue of his illnes His rapidly changing body makes him prone to thi feeling anyway.

2. He may feel a lack of perfection. The narcissism of the adolescent is such that he may fee a small facial blemish as a terribly disfiguring lesion. Thus, the pediatrician must deal with th "trivial" as important, serious matters.

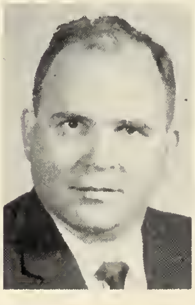
3. He may see it as a threat to his independence He wonders if this illness will restrict him, put hi "out of commission," particularly with his peers.

4. He may interpret it as a threat to his masculine or feminine image.

5. He may feel guilty associating it with som forbidden feeling or impulse—sexual or aggressive

The unconscious "use" of the somatic illness depends upon the emotional development of th adolescent and his relationship to his parent. Man times the incapacity of a somatic illness in adolescence is due more importantly to the psychologic reaction of the adolescent than to the actual illne itself. Thus, a disturbed adolescent-parent relationship will tend to aggravate the incapacities o that adolescent when he is ill.

The adolescent may unconsciously need to mai



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in his dependency upon his parents through the lness. Contrariwise, he may have to assert his dependence from his parents by denying his illess. He may use the illness as an aggressive reacon against his parents with whom he is struggling.

SYCHOLOGICAL CONSIDERATION F SERIOUS ILLNESSES ADOLESCENCE

Next, let us consider several of the more serious matic or psychosomatic illnesses which occur durg this period. We can thus illustrate some of the namic meaning of these conditions and the chalnges in their management. The following exmples are not meant to cover completely all of e syndromes nor their exposition.

1. *Anorexia nervosa:* This syndrome is characrized by extreme weight loss, a diminution of apetite and associated amenorrhea without physiogical cause.[4] This syndrome can occur in a variety disorders: In girls who are basically hysterical, mpulsive or schizoid. Some can be borderline or sychotic. All are seriously emotionally ill. The nflicts in these girls regarding their growing up resents a crisis which is met by regression in a sition in which eating is once again a battleround and a way of getting some form of concern.

In most of these children hospitalization is necesry since outpatient treatment is ineffective. Mangement may require separation from the home in hich the child and parents are locked in a hopess struggle around the eating issue. Sometimes to nserve life, tube feeding is essential. Despite the vert resistance of the patient, the giving up of the athological control to the physician is a relief and n dramatically begin a shift toward physical and sychological health.

When the patient accepts the fact that the docr and the staff of the hospital are all concerned ith her welfare, then her medical experience can e an important corrective emotional experience.

EXAMPLE: A young adolescent girl of 12 and ne-half years was admitted to a children's psyhiatric residential treatment center after four onths' trial of outpatient assistance which ended failure. Originally weighing 90 pounds one year reviously, she was now down to 47 and one-half ounds, looking cadaveric and emaciated. When e doctor became concerned with secondary mebolic disturbances, the child was admitted to the sychiatric facility.

Soon thereafter her psychiatrist carefully exlained to her why she had to eat. He said hat her illness prevented her from having an apetite or a willingness to cooperate, but to preserve er health and perhaps her life, eating was essenial. When she did not eat after a few days' trial, he was shown a stomach tube, and told that tube feeding would proceed unless she consumed the prescribed diet. Tearfully, angrily she ate, meanwhile telling the doctor what a mean, un-understanding person he was. Once her pathological control over eating was taken away, she became more comfortable in the hospital setting. Eventually she made a good, positive relationship to her doctor.

Her subsequent course in the hospital showed she had a longstanding, serious illness with borderline psychotic qualities. Her condition required several years of intensive treatment and her improvement was only partial. Years later, as a 21-year-old woman, she told her doctor that secretly she had appreciated the strength he had shown in helping her to face her eating problem.

2. *Diabetes:* The child with juvenile diabetes who does not adjust to his illness may need grossly to deny his illness and thus be unable to assume responsibility of self-management which his illness requires.[5] The young diabetic patient brands himself as different in a negative way and feels he is restricted unfairly. Guilt about his affliction and hostility toward his parents complete the picture.

Here the doctor needs to be a sympathetic supporter of a child who is upset with his illness and, at the same time, be an interpreter to that child of the reality of his situation. The pediatrician understands that it will take time for the child to accept emotionally his own illness. The doctor may be confronted by the adolescent's occasional or frequent failures to manage his illness.

The pediatrician hopefully sees these failures in the context of the patient's emotional struggles against the unwanted burden of his diabetes. If so, he will not convey to the adolescent a sense of disapproval which discourages the child from using the doctor because of the child's guilt.

EXAMPLE: A 13-year-old girl with juvenile diabetes was seen for residential psychiatric treatment because of poor control of her diabetes, severe periods of depression, and some acting-out behavior including lying and stealing. She had frequent alternating comas and hyper-insulin reactions. Her diabetes was diagnosed by a pediatrician at 10. She was never in good control because of her poor cooperation in keeping to a diet and her insulin injections. Contributing to her poor reaction to her illness was her chaotic family situation—an unstable, rejecting mother and a brutal, suspicious father who had divorced. Despite these disturbing factors, her pediatrician, toward whom she was attached, was able to support her effectively for three years.

After running away and precipitating a diabetic coma and shock she was admitted to the psychiatric hospital. She expressed depressive feelings, stated that she knew how to destroy herself through the misuse of the diet and insulin. Later, as her overall status improved, she talked about her reaction to her diabetes. She said, "I just felt different from other kids. I couldn't have a lot of sweets, and I like sweets. I thought the other kids were laughing behind my back. I didn't think kids wanted me as a friend so I worked harder in school. I stole money from my mother to buy friends."

The therapeutic environment in the treatment center allowed for gratifying relationships with both female and male staff members. An important aspect of her psychotherapy was to clarify her attitudes toward her diabetes and to understand how her feelings toward herself and her parents determined her distorted behavior toward her illness. Initially she acted as if she did not need certain food restrictions and did not need to check her urine (denial of illness).

Gradually she was able to assume a more mature responsibility toward administrating her daily insulin and toward her diet.

3. *Colitis:* The adolescent with ulcerative colitis is usually quite sick emotionally. He is an obsessive-compulsive kind of person, aggression inhibited, polite, pseudo-mature and intellectualizing, bland and isolated in affect, socially remote with few friends. The family shows a particular kind of marital balance in which the mother is the strong dominant force. It is she who struggles with the child. He, in turn, may seemingly accede to the mother's wishes but somatically his angry and rebellious feelings are expressed through his intestinal malfunction. The father is characteristically distant and weak appearing.

The acute phase of this disease brings up the question of special handling. During this phase it is helpful for the doctor to allow the patient to regress, figuratively to return to a less complex, more gratifying existence where his more childish needs are met as fully as possible. Such therapy has been called "anaclitic" in an attempt to describe the giving to the sick adolescent a gratifying, palliative mothering experience.

Certainly the doctor can make use of the basic personality of such patients by helping them to use constructively their compulsive defenses. They can be taught to regulate their activities, their diet their medications in a structured fashion.

EXAMPLE: A 14-year-old girl was put into general hospital because of her frequent, watery mucus containing, cramping bowel movements—sometimes up to 40 daily. A question of som bleeding in the stools was raised. A sigmoidoscop revealed an erythematous mucosa, but no actua ulcerations. Her mother was an anxious but over controlling person who complained about th daughter's occasional rebelliousness and uncooperativeness in her diet and medication. Despite thi behavior the patient appeared to be a bland, inhibited girl with few friends. Her father was typically uninvolved and himself greatly concerne with a bleeding peptic ulcer and a recommendation for surgery. An older brother of 19 had had subtotal colectomy for ulcerative colitis and ha the more typical obsessive-compulsive personalit described for this kind of person.

The girl resented her mother's great concern fo the brother and viewed her mother as partially rejecting her. She was frightened about her eventually needing a colectomy like her sibling. The gi eventually needed residential psychiatric treatmen because of her great despair about her illness an a question of possible suicide. Had the famil greater strengths and had they been able, unde the direction of the family physician, to rally support for the girl, such comprehensive psychiatri help might not have been necessary.

Unlike some adolescents with colitis, her illnes overwhelmed her and she could not continue on normative track meeting her ordinary tasks sufficiently well.

4. *Bronchial asthma:* Perhaps this syndrome ca illustrate more than most the point that the psychological response of the child and his parents to hi illness more than the actual physical illness itsel may determine the degree of impairment whic that child will suffer.

In an interesting study carried out by allergist at the University of Michigan Medical Center an child psychiatrists at Hawthorn Center a group seventy-one children with chronic bronchial asthm and their families were seen.[6] No positive rel tionship was found between the severity of th asthmatic situation (onset, severity, response t

> *The adolescent's emotional reaction to physical illness is influence by his unique developmental phase, family and past experiences. Frequently, neurotic-like feelings and behavior mobilized by illness incapacitate him more than his physical status. The patient-physicia relationship may become crucially important in reducing the adolescent unrealistic fears about his illness and to help him accept necessar limitations and medical management.*

atment) and the family situation (quality of nily relationships, identification opportunities, re hand handling). However, a very high positive rrelation could be seen between the disturbance the child's personality, and disturbances within e family setting and the impact of the asthmatic ndition upon the child's life. Thus, a child with ld asthma who is emotionally disturbed, whose nily environment is pathological may incorporate fact of his asthma into his psychic life so as to pple him.

Conversely, even the child with severe asthma ose personality and the family situation is intact y not have significant impairments in adjust- ent. The family who is precariously balanced yway may react to the child's asthma quite nega- ely. Because of the nature of the illness and the endant problems asthma places in the way of ain on family living there is a particular urgent ed to control it medically wherever possible.

The group of asthmatics with severe emotional ficulties were highly anxious about death and d other morbid preoccupations. The group with eater emotional health had much less serious re- tions. A major factor in reducing the child's fear asthma was the availability of immediate relief ough medication. The reality threat was made nimal as the child developed a confidence in the dication.

The most commonly expressed feeling by the ildren about their illness was one of frustration cause it interfered with the realization of their ns and with their social life. The study indicated t routine referral of the asthmatic child for chiatric help was not necessary. However, the hmatic child who is disturbed may require psy- iatric help with psychiatric casework indicated many of the parents. In these instances the co- eration of the pediatrician, child psychiatrist, and psychiatric social worker is imperative.

5. *Epilepsy:* Much has been written about some the emotional factors in relation to the child or olescent with epilepsy. Some authors have essed the inverse relationship between seizures d behavior problems.[7] In other words, to control e seizures is to make the behavior problem worse. ithout attempting to resolve this question I would tegorically stress that the first task in trying to lp such an adolescent would be to control his zures as completely as possible. The feeling the epileptic adolescent that he is different, that is pointed out and tagged as something queer very strong. He dreads having a seizure in nt of his friends or in school. Necessary re- ictions in certain kinds of sports, in driving a r are resented. The doctor must spend his time, obably on a serial basis, explaining the condition the patient stressing as much what the illness does not mean, what limitations he will not have as a result of it. Commonly associated are problems with aggression, instances of rage and physical acting out. Appealing to the child on the basis of what is selfishly best for him can sometimes be of help here.

THE USE OF THE PEDIATRICIAN

1. The adolescent may become closely identified with the pediatrician. The doctor is the one who has known him, who has a unique position toward him and toward his family. The pediatrician has seen him through past medical crises as well as his present apparent or real physical illness.

2. The adolescent is capable of using—despite his temporary inimicability toward his parents—a trustworthy, dependable adult. Indeed the doctor is viewed as different from his parents and has a built-in advantage in the relationship.

3. The adolescent can be given a chance to sit down and communicate his own thinking and feeling about his real or apparent medical ailment. The doctor's attitude which says that he invites the adolescent to talk is crucial. If he conveys, for example, that he is too busy or disinterested, the adolescent will pick up the cue and not speak.

4. He may require serial visits before he "opens up." Thus, the following of a disease may be done not on the basis of strict physical necessity but may be guided by the need to set up an interpersonal situation where eventual meaningful communication can take place.

5. The doctor should recognize the importance of the "disguised communication." In his asking for information regarding his illness the adolescent may be sizing up the doctor's attitude toward the disease and toward him and will then determine if he can discuss anxiety-laden areas with the doctor.

6. An informal, friendly, interested atmosphere is important. However, this does not mean that the doctor need become "one of the boys" or act the part. The adolescent does not want the doctor to relinquish his professional role.

7. The use of a one-to-one relationship with the adolescent and keeping the parents in the background can encourage the adolescent's own responsibility for his illness, his own sense of involvement and participation. It may encourage a more mature attitude toward his illness than relinquishing concern for his illness to his parents.

8. This does not preclude the doctor's working with the parents as well. In part, the parents' attitude toward the illness, their own anxieties, and their own unrealistic phantasies about it are pertinent factors. Sometimes, seeing the parents and the adolescent together around specific issues assist in clarifying some misunderstanding in interpreting

of the illness and resolving questions and disputes around treatment programs.

9. It is important to help the adolescent to understand his feelings toward his illness. It may help the doctor to know in which area he may orient, clarify, and help the patient cope with his illness.

10. The doctor's task is not only to help the adolescent accept the realistic limitations his illness imposes upon him, but to take the unrealistic restrictions away which his own anxieties have constructed. In other words, the doctor can help the adolescent place his illness into proper perspective. He must somehow convey a positive approach in which he can (if at all possible) indicate to his patient that his future goals are attainable, that the road to a gratifying and useful adulthood is open to him despite his illness.

11. The adolescent may not need deep insight into the psychological meaning of his somatic illness. Rather he needs the support and understanding of an interested, dependable doctor as he copes with his physical illness and finally masters it.

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From the Mailbag

Dear Doctor Tupper:

Several months ago, under the leadership and counsel of Doctor Harry Saltzstein of Detroit, a group of physicians formed what we now call The Detroit Cancer Club.

Our first meeting was held in the second week of September, 1965, and was attended by well over 150 physicians. This was greater than the expectations of any of us who had assisted Doctor Saltzstein in planning and carrying out the organizational work of getting such a group started.

Our first scientific program consisted of two discussions, one on the Ten Year Review of Mammography by Doctor John Wolfe of Woman's Hospital with a discussion by Doctor Andrew Poznanski of Henry Ford Hospital. The second paper was on The Role of Hospital Tumor Registry in Maintaining Adequate Patient Care by Doctor Izidore Selzer of the Michigan Cancer Registry with the discussion by Doctor Michael J. Brennan of the Henry Ford Hospital.

The next program was held on November 23, 1965, on Lymphosarcoma. This program had the following participants: Doctor A. A. Kambouris of Harper Hospital, Doctor R. J. Bloor of Henry Ford Hospital, Doctor Freeman Wilner of Providence Hospital, and Doctor N. W. Arends, D.O. of Detroit Osteopathic Hospital.

As Chairman of the Program Committee, I have been asked by the Steering Committee of The Detroit Cancer Club to contact you and see if it woul be feasible to have a summary of these scientifi programs presented and published in MICHIGA MEDICINE. It is contemplated that we will have fro three to five such scientific programs a year, an that the material will be summarized to take n more than a page or a page and a half of journa space.

By the way, membership in the Detroit Cance Club is not specifically limited to the Detroit are We do have physicians from Ann Arbor and sur rounding counties—Macomb, Oakland, Monroe an Washtenaw who attended our first meeting. Mem bership is open to any physician who is practicin medicine, and having "more than the average inte est in cancer."

I would appreciate any comments that you migh have.

Very sincerely yours,
ROBERT W. TALLEY, M.D.
Chairman, Program Committe
The Detroit Cancer Club
25351 Frederick
Southfield

It costs hospitals twice as much to care for patient today as it did 10 years ago. The cost ha increased from $18.35 to $36.83 a day, primaril because of rising wages of hospital personnel, ne equipment, and new services.—Trauma, 5, 1965.

**ORIGINAL
SCIENTIFIC
ARTICLE**

Hydatidiform mole, uncommon in this country, is particularly rare fter age 50. The case of a 52-year-old woman with hydatidiform ole, successfully treated by hysterectomy, is presented. There is a much igher incidence of malignant change in the older age groups so that he treatment of choice for elderly multiparas with hydatidiform mole hould be hysterectomy.

Hydatidiform Mole In an Older Woman

lorton R. Lazar, M.D., F.A.C.O.G.
ugene A. Snider, M.D.

Hydatidiform mole is a relatively rare complica-on of pregnancy. The incidence is variously re-orted as ranging from 1 in 1,321 pregnancies to in 4,000.[4,6,7] In Asiatic women, the disease is uch more frequent. Apelo[3] reported an incidence f 1 in 370, a figure comparable with Acosta-Sison's[2] 77 in 25,669 deliveries.

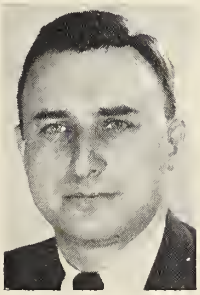
There undoubtedly is an increased incidence of ydatidiform mole in pregnancies occurring in the ter decades. Malignancy from a mole may occur t any age, but its relative incidence seems to in-rease progressively with age.[1] Acosta-Sison, in a hilippine Islands study, showed an increase of ydatidiform mole from .38 per cent of all preg-ancies in the 15 to 19-year age group, to 2.38 per ent in the 40 to 49-year group. In the 50 to 59-ear age group the rate increases abruptly to 12.57 er cent.

It is to be noted that these statistics are derived om the Philippine Islands where the incidence of ydatidiform mole is known to be considerably igher than in the United States. The occurrence of chorionic malignancy in turn appears to increase with the age of the patient. Acosta-Sison's studies demonstrated an increasing trend toward malignant change from 5.56 per cent in the 17 to 19-year range to 55 per cent in the 45 to 59-year range.

Since pregnancy itself occurs uncommonly after the age of 50, hydatidiform mole in this age group would consequently be rare. Only 61 cases[5] of hydatidiform mole in women over the age of 50 have been reported in the world literature.

A patient, age 52, with a hydatidiform mole was successfully treated. In view of its rarity in the age group, as noted above, it was deemed worthy of reporting.

Dr. Lazar



Dr. Snider

CASE REPORT

A 52-year-old gravida 2, para 2, was seen January 2, 1963, with symptoms of vaginal spotting for 14 days. Her last normal menstrual period occurred on November 15, 1962. The past history was irrelevant.

Routine pelvic examination in 1961 revealed no pelvic masses. Pelvic examination at this visit revealed a large multinodular uterus extending well above the symphysis. The Papanicolaou smear test was performed and was subsequently reported negative for malignancy. Thus the clinical course was one of rapid enlargement of the uterus with vaginal bleeding and the diagnosis of a myomatous uterus was made. A total abdominal hysterectomy, bilateral salpingo-oöphorectomy and incidental appendectomy was accordingly performed. The findings at operation consisted of bilateral cystic ovaries and a large myomatous uterus.

GROSS PATHOLOGIC DESCRIPTION

The uterus weighed 386 grams and measured 12 cm from fundus to internal os, 6.2 cm from cornu to cornu and 8.5 cm in A.P. diameter near the fundus. The posterior wall of the uterus contained a subserous and interstitial nodule measuring 7 x 7 x 6 cms. In addition there were several small nodules anteriorly. The endometrial cavity was filled with gray-black soft cystic polypoid structures weighing 20 gms. No fetus was found, nor was there evidence of normal placental tissue. The tubes were normal. The left ovary was cystic, and measured 2.7 x 2.0 x 1.5 cms, and contained a clear yellowish fluid. The right ovary measured 2.5 x 1.5 x 1.7 cms, and was similar to the left ovary.

MICROSCOPIC PATHOLOGIC DESCRIPTION

Sections of the tissue from the uterine cavity revealed numerous large hydropic chorionic villi of varying size and shape. The stromal blood vessels were absent. There were numerous foci of trophoblastic proliferation in which the nuclei were large, of varying shape showing chromatin. Some of the trophoblasts appeared as papillary projections from the outer layer of the villi. The uterine endometrial stroma showed decidual changes and there were numerous large hyperchromatic cells with bizarre nuclei present in the upper layer. Some were multinucleated. A few cells were infiltrated into the upper layer of the myometrium. Sections of an interstitial nodule revealed nests of endometrial glands with small amounts of stroma in the intermingled myometrium. Other nodules revealed uniform spindle shape cells in interlacing bands. Sections of the ovaries revealed the presence of corpus luteum cysts, and numerous atrophic follicles. The pathologic diagnoses were hydatidiform mole, adenomyosis, leiomyomata uteri and corpus luteum cysts.

Postoperatively, the patient was followed with periodic serum gonadotrophin levels, which remained negative in all concentrations. A chest roentgenogram performed the day prior to operation was reported normal.

DISCUSSION

With the establishment of the diagnosis of hydatidiform mole, there should be no delay in treatment. There should be no alternative other than immediate emptying of the uterus by medical or surgical means. It is even of greater importance in the older age groups. As previously stated the incidence of malignancy increases with advancing age. Therefore, the best therapy for hydatidiform mole in elderly multiparas, especially after 39 and certainly, after age 45, is hysterectomy with mole *in situ*.[2,8] Obviously, it is essential that these patients be closely followed for recurrent manifestations by means of roentgenograms and gonadotrophin estimations. With the findings of malignancy, hysterectomy with the mole *in toto* may be a life-saving measure.

SUMMARY

Hydatidiform mole is uncommon in this country, and is particularly rare after 50 years of age. All elderly multiparas with a diagnosis of hydatidiform mole should be subjected to hysterectomy in view of the high incidence of malignant change in the older age group.

A case of hydatidiform mole in a 52-year-old woman was successfully treated in this manner.

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Coming in February

Next month, watch for an interesting article on the surgical treatment of massive pulmonary embolism by Paul Firnschild, M.D., of Detroit. Harold Oberman, M.D., and his colleagues in the department of pathology at the University of Michigan present a timely article on Plasmapheresis as an alternate form of blood donation that can greatly increase the capacity of a transfusion service.

Paul S. Rhoads, M.D., former editor of the Archives of Internal Medicine and member of the AMA Committee on Medicine and Religion, discusses the meeting ground of psychiatry and religion.

These and additional articles of broad interest will merit your careful consideration.

ADIOS

All editorials are difficult to write.

This one is perhaps the most difficult of all. Two years and a few months ago, your editor joined the staff of the Journal of the Michigan State Medical Society, now called MICHIGAN MEDICINE. The intervening time has passed swiftly, eventfully, and most often pleasantly.

Early, my term as editor was saddened by the unexpected death of William Scott, M.D., Chairman of the Publication Committee. His loss was a great one. Bradley M. Harris, M.D., then accepted that responsibility and has supported me and guided me with strength and wisdom, as have all the members of the Publications Committee. Many people have been helpful in many ways.

The members of the Society as readers, the hundreds of members who have contributed scientific articles of ever-increasing quality, the officers and staff of the State Medical Society. But, most of all, my thanks and appreciation go to Herbert Auer, managing editor, for his high competence in journalism; my secretary, Mrs. Bernadine Giraud, for her untiring assistance; and last, but by no means least, to my wife and children for their understanding of the time demand for working with manuscripts into the night.

But it has been great fun, deeply satisfying, and a good team effort. I think we can look at our journal with pride, for it is a good journal and will become even better. Many, many changes have been made and more improvements are still to come.

As many of you know, I leave now to assume a new responsibility as professor of medicine and dean of a new medical school at the Davis campus of the University of California, near Sacramento, the state capital. It is my hope to continue to emphasize the absolutely essential spirit of understanding and cooperation that must exist between academic medicine and the medical community.

I am sure the new editor of MICHIGAN MEDICINE will also continue to work toward this objective. He will have the support of an excellent Publications Committee, a superb staff, and an outstanding managing editor. I say Adios, then, with deep nostalgia but with pride in what we have accomplished together and with great confidence in the future of the Michigan State Medical Society in general, and the future of MICHIGAN MEDICINE and its new editor in particular.

In the words of my dear friend, A. C. Furstenberg, M.D., "Nothing succeeds like a successor."

—C. J. TUPPER, M.D.

BE ON ALERT

Mid-winter is the time of peak incidence of rheumatic fever and children of school age are the special targets of this disease. Streptococcal infections are the cause of more long-term disablements in children than any other disease.

More than 1,200,000 Americans over the age of 18 have rheumatic heart disease, so parents and teachers, along with physicians, should sharpen their concern for the early diagnosis and effective treatment of streptococcal infection in order that rheumatic fever be diminished in incidence.

DIFFERENT IN U.S.A.

"The Americans of all ages, all conditions and all dispositions constantly form associations. They have not only commercial and manufacturing companies in which all take part but associations of a thousand other kinds, religious, moral, serious, futile, restricted, enormous, or diminutive. The Americans make associations to give entertainments, to found establishments for education, to send missionaries to the antipodes. Wherever at the head of some new undertaking you see the government of France or a man of rank in England, in the United States you will be sure to find an association."

ALEXIS DE TOCQUEVILLE
1805-1859

From The Mailbag

Members are invited to submit to MICHIGAN MEDICINE any suggestions for the welfare of the *Society, as well as comments or criticisms of any material in* MICHIGAN MEDICINE. *All such communications should be directed to the Publications Committee of the* MICHIGAN MEDICINE. *The Publications Committee reserves the right to publish, reject, edit, or abbreviate all communications submitted to it.*

Thank you for the copy of MICHIGAN MEDICINE bearing on its cover a picture of the marker marking the place where the Michigan State Medical Society was born.

I was interested in the piece on page 802, "Historic Markers by County Societies are Good Projects."

Under the act passed by the state legislature a few years ago, the Michigan Historical Commission has registered both state historic sites and also local historic sites. Registration of a site must be approved by the Commission. Any person may apply to have a site registered. Official markers are available for local sites. They are similar to the official markers for state sites, except that they bear, at the bottom, "Michigan Historical Commission, Registered Local Site No. ...."

Perhaps the possibility of registering local sites and having available these markers for them might be of sufficient interest to your readers to warrant mentioning this in a later issue.

Sincerely,

WILLIS F. DUNBAR, Member
Michigan Historical Commission
Kalamazoo

(Note: The following interesting letter was received by MSMS President Luther R. Leader, M.D., in response to MSMS questionnaire re international health overseas service.)

Dear Doctor Leader:

I was very happy to read your letter of November 4. To me it was welcome evidence of a great advance in the altruistic spirit of modern medicine.

After my graduation from the University of Michigan Medical School in 1912 I had two years' service in the Department of Ophthalmology of the University Hospital.

During those years I was attracted by the idea of medical missionary work in China because of the great need for modern ophthalmology and because I felt that Christian service there would be helpful to the Chinese in the transition from the Monarchy to the hoped-for Republic.

When my colleagues learned of my plan they regarded me as something like a "freak" and two of the medical faculty called me in for an interview in which they endeavored to dissuade me from such a wild idea. . . . "Good doctors are needed here" . . . "Waste your time and effort on unappreciative Chinese" . . . "You will lose your contact with the progress of medicine" . . . "The Chinese are happy with their own way of life," etc.

I believe that they were sincere in desiring for me the best for my future, but at that time altruism in medicine was provincial and did not have the international outlook which I was so pleased to note in your letter.

Mrs. Smith and I were in Peking, China, under The Methodist Church Mission Board from 1915 through 1928 and we regard the experiences of those years as most valuable and their memory very precious.

I hope that your letter will be given serious consideration by many who are so situated that they can respond to its challenge.

With best wishes,

DENNIS V. SMITH, M.D.
1435 Cambridge Rd.
Ann Arbor, Michigan

Mark Your Calendar For Annual Sessions

The MSMS Council has approved the following dates and locations for upcoming Annual Sessions of the Michigan State Medical Society:

1966—Grand Rapids, Sept. 25-30
1967—Grand Rapids, Sept. 24-29
1968—Detroit, Sept. 22-27

BEG PARDON

An article about MSMS postgraduate educational activities in the November issue incorrectly identified Walter P. Work, M.D., as a member of the WSU Medical School faculty. He is a professor and chairman of the U-M Medical School Department of Otorhinolaryngology.

"I want to thank you for the opportunity to have served as editor of Michigan Medicine," says C. J. Tupper, M.D., center, as he attends his last meeting of The MSMS Council, December 15. At left is B. M. Harris, M.D., Chairman MSMS Publication Committee, and at right, Harold H. Hiscock, M.D., Chairman, MSMS Council.

Doctor Tupper Going to California; Lauded for Contributions as Editor

"The residents and physicians of Michigan will miss this man — Doctor Tupper has contributed much to the medical profession, to education, to the community and especially to MICHIGAN MEDICINE.

So stated B. M. Harris, M.D., chairman of the MSMS Publication Committee and MSMS Councilor from Ypsilanti, in a short ceremony before The MSMS Council December 15. Tributes were also paid by Harold H. Hiscock, M.D., Flint, chairman of the MSMS Council and others.

C. J. Tupper, M.D., that morning, had submitted his resignation as scientific editor of MICHIGAN MEDICINE after more than two years of service. Doctor Tupper will begin duties February 1 as the dean of the University of California's newest medical school at Davis.

Doctor Tupper leaves as associate dean of the University of Michigan Medical School, as a member of the Michigan Blue Shield Board, and as active participant in several medical organizations. He is a past president of the Washtenaw County Medical Society which honored him December 14 at its county meeting.

Dates to Help Patients Use Medicare Aid

Here are some important dates to remember as the 1965 Amendments to Social Security put the Medicare Program into effect:

February 1—A follow-up enrollment form for supplementary medical insurance under medicare will be sent to Social Security beneficiaries who haven't answered "yes" or "no" on forms mailed to them in 1965,

March 31—First enrollment period for supplementary medical insurance ends. Eligible persons who haven't signed up, and these eligibles include men and women over 65 but not drawing Social Security benefits, will have to wait until October 1, 1967, for the next enrollment period and pay higher premiums.

April 1—Social Security Administration will begin issuing medicare cards to all persons over 65 qualified for health-insurance program.

July 1—Hospital and home-health benefits under the medicare program take effect. Supplementary medical insurance also goes into effect, with the exception of Post-Hospital Extended Care.

January 1, 1967—Post-Hospital Extended Care benefits go into effect.

Counting Ballots For Judicial Commission

MSMS members will watch for their January issue of *Medigram* to find out who were the 10 physicians elected to the MSMS Judicial Commission.

Ballots were sent to every member and were to be returned not later than December 30 to the MSMS headquarters.

Following are the names of the nominees, in alphabetical order:

District 1 — Louis J. Bailey, M.D., Southfield; Arthur M. Clark, M.D., Dearborn; Robert B. Clarke, M.D., Detroit; Wyman C. C. Cole, Sr., M.D., Detroit; Hugh M. Fuller, M.D., Detroit; A. H. Hirschfeld, M.D., Detroit; Robert P. Lytle, M.D., Southfield; Clarke M. McColl, M.D., Detroit; Raymond A. Sokolov, M.D., Detroit; Donald N. Sweeny, Jr., M.D., Detroit; Joseph A. Witter, M.D., Highland Park.

District 2 — Harold A. Furlong, M.D., Pontiac; Donald A. Koch, M.D., Port Huron.

District 3 — Kenneth H. Johnson, M.D., Lansing; Norman F. Miller, M.D., Ann Arbor; Claude L. Weston, M.D., Owosso.

District 4 — Robert T. Blackhurst, M.D., Midland; H. Maxwell Golden, M.D., Flint; Orlen J. Johnson, M.D., Bay City; Robert F. Powers, M.D., Saginaw.

District 5 — Sherman E. Andrews, M.D. Kalamazoo; James I. Clark, M.D., Fenville; Robert K. Curry, M.D., Homer; Harold J. Meier, M.D., Coldwater; Andrew K. Payne, M.D., Jackson.

District 6 — Carl B. Beeman, M.D., Grand Rapids; Charles E. Stevens, M.D., Greenville; H. Clay Tellman, M.D., Muskegon.

District 7 — James R. Dehlin, Gladstone; Reeder J. Hubbell, M.D., Traverse City.

Activities Focus on Community Health Week

Many component county medical societies capitalized on Michigan Community Health Week during November to conduct various health-related projects.

The Michigan-wide activities were carried out by the Michigan Health Council, Michigan Association of the Professions and the Michigan State Medical Society.

Michigan's Astronaut Jim McDivitt, Jr., of Jackson, was paid special tribute along with the entire McDivitt family by being designated as "Michigan's Community Health Family." The astronaut's mother and other members of the immediate family have served in the nursing profession and his brother-in-law, James Shehan, D.D.S., is an orthodontist at Jackson.

* * *

THE FOLLOWING reports are typical of the ambitious local projects:

The Jackson County Medical Society celebrated Community Health Week by having the MSMS Healthmobile on display, and with a diabetic detection program that reached 4,556 persons.

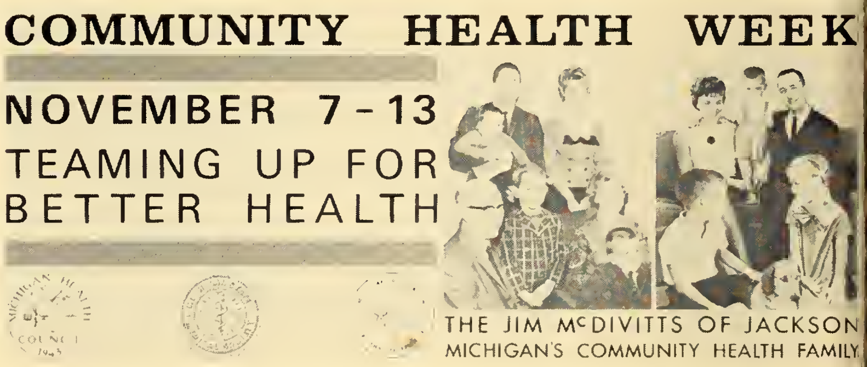
In Muskegon, 64 physicians participated in a Muskegon County Medical Society public-service project to keep their offices open one evening to provide free tetanus shots. The response was enthusiastic. The results of a county society questionnaire were released the same week to show the wide scope of community services performed by doctors in their spare time.

* * *

THE OAKLAND County Medical Society released a series of special newspaper stories dealing with various diseases and illnesses. Radio and television also were used.

At Cadillac, Sault Ste. Marie and Grand Rapids, the Michigan Health Council and local physicians presented television programs about physical fitness.

At Traverse City, Port Huron and Petoskey, the county medical societies during Community Health Week heard lectures by medical authorities sent by the MSMS Committee on Postgraduate Medical Education.



COMMUNITY HEALTH WEEK

NOVEMBER 7-13

TEAMING UP FOR BETTER HEALTH

THE JIM McDIVITTS OF JACKSON

MICHIGAN'S COMMUNITY HEALTH FAMILY

This poster was used extensively throughout Michigan.

Did You Reply?

The MSMS Maternal Health Commitee mailed in mid December the "Maternal Health Desk Card No. 6" to 2,000 Michigan doctors who deliver babies and asked the recipients to return an evaluation postal card.

The return-type card asked the physicians if they read the Desk Reference Cards and if they were of value.

The sixth card in the series was about the "Premature Separation of the Normally Implanted Placenta."

A New Year's Resolution

By Noyes L. Avery, Jr., M.D., Grand Rapids

WHEREAS (WAS)—It is fitting we Physicians Take Stock (PTS) (inventory, etc.) from time to time,—and (+)

WAS—The Beginning of the New Year (BNY) occurs only too seldom for such purposes,+

WAS—Our Sins of Omission and Commission (SO & C) accumulate now by Geometric Progression (GP), and where formerly it was by mere Arithmetic Progression (AP),+

WAS—We Physicians are so engaged with the Healing Arts (HA) at the Local Level (LL), we fail to recognize the Total Demand (TD) made upon us and the HA

THEREFORE BE IT RESOLVED (TBIR)
That New Year Resolutions (NYR) at BNY be discontinued and be replaced by the Quarterly System of Resolutions (QSR),+
Be It Further Resolved (BIFR) that at least as much force be engendered for QSR as has been the case for NYR,+

BIFR—That our SO&C be thus brought down from an increase by GP to one by at least AP,+

BIFR—That the TD of HA at LL be constantly in mind when PTS,+

BIFR—That NYR and proposed QSR are not DOA.*

---

*DOA—Dead On Admission.

MSMS Resolutions Fared Well

By

Wm. A. Hyland, M.D., Chairman,
MSMS Delegation to AMA

The Michigan delegates at the AMA House of Delegates meeting n Philadelphia introduced eight esolutions. All in all we fared very vell; our resolutions were acted ipon as we wished and the two for tudy were accepted as such.

Several of the resolutions had een recommended by the MSMS Iouse of Delegates in September nd several were proposed by Aichigan physicians who are serving as section delegates to the AMA House. We were asked by he Michigan representatives to put hem in as Michigan resolutions be:ause they felt they would carry nore weight from a state rather han an individual section.

The Michigan representatives in:lude Harold F. Falls, M.D., Ann Arbor, for Ophthalmology; Edgar E. Martmer, M.D., Detroit, Pediarics; Clarence S. Livingood, M.D., Grosse Pointe, Dermatology; and ohn M. Sheldon, M.D., Ann Aror, Internal Medicine. It is very inusual for one state to have as nany representatives from the secions. I recall this particularly to mphasize that the American Medcal Association has repeatedly informed us that Michigan has more han its share of representatives n various American Medical Asociation activities.

The 1965 MSMS House of Delegates adopted a resolution by D. Honta Hiscoe, M.D., Lansing, which urged a continuing study of he role of medicine in society. This resolution was much like the North Carolina resolution which vas adopted by the AMA in June 1965 and which also recommended a committee for study. The AMA study committee was instructed to consider the proposals in the Hiscoe-Michigan resolution.

The 1965 MSMS House also adopted a resolution by Frank H. Power, M.D., Traverse City, which would have provided a considerable turnabout on the part of the AMA. It would have provided for actions relating to medicine from the top down. Our delegates felt it would not hurt to have the AMA take a good look at the proposal. Your Michigan delegation urged that Doctor Power be given a hearing on this resolution when the study committee gets under way.

One other resolution by I. W. Silver, M.D., of Detroit, put in by the Michigan Delegates urged that all hospitals recognize the general practitioner and let him care for his patients — this he stated the American Medical Association was to insist upon and direct. The reference committee urged all hospitals to recognize the generalist in as far as consistent with hospital rules and again reiterated its position on this matter, as the same on three other occasions during the past ten years. But the American Medical Association definitely states it is not within their purview to control hospital practice.

We also presented a resolution on the efficiency of simplified reports on all medicare cases consistent with adequate care and description of the cases — this was also passed.

The other resolutions presented by the Michigan Delegates relating to retaining the sections in the House of Delegates — The Ad Hoc or Gunderson Committee had recommended for the third time to be changed to have these sections under the Board of Trustees and thus lose some of their independence — the sections objected to this change and were overwhelmingly supported by the House.

* * *

Comprehensive reports of the Philadelphia meeting have been printed in the AMA News, and will not be duplicated in MICHIGAN MEDICINE.

* * *

The Michigan delegation at Philadelphia included Doctors Sidney Adler, John Heidenreich, Luther R. Leader, G. W. Slagle, Donald N. Sweeny, Jr., and Doctor Hyland. Alternate Delegate Bradley M. Harris was seated to serve for Orlen J. Johnson, M.D., who was unable to attend.

State to Poll Doctors About Merger Idea

The State Affairs Committee of the Michigan House of Representatives soon will send a confidential questionnaire to every physician and osteopath asking for their views on a possible merger.

Such an opinion survey was one of the outgrowths of a public hearing held in Detroit, November 19-20, by the committee of legislators.

MSMS was invited to testify at the hearing and John J. Coury, M.D., Port Huron, MSMS spokesman, said in part:

"Amalgamation of the doctors of osteopathy and doctors of medicine is the road to the best in health care for the people of Michigan."

Doctor Coury urged the Committee "to encourage unity between doctors of medicine and doctors of osteopathy" and not to discourage such unity through the construction of a proposed state-financed school of osteopathic medicine.

Positive steps taken by the state medical society toward amalgamation were reported by Doctor Coury.

"The inquiries and encouragement have mounted greatly from osteopaths for a merger," Doctor Coury reported.

Doctor Coury, chairman of the MSMS Committee on Medicine and Osteopathy, declared that "Amalgamation is the most economical and most efficient way to assure the best possible health care for the people of Michigan. A merger would assure better quality of medical care, and more effective postgraduate training, and would avoid unnecessary duplication of educational institutions, hospitals and other health-care facilities."

The survey results will be considered by the Committee members as they consider the DO College bill approved in the last session by the Michigan Senate.

Patients Tell Why They Used Emergency Rooms in Hospitals

By Richard M. Campau,
MSMS Research Director

Michigan Blue Cross recently released a major research report examining why patients are making ever-increasing use of hospital emergency rooms. The findings indicate that:

1. Hospitals are viewed by most people as community health centers.
2. Greater numbers of emergencies make increasing demands on physicians, and the nature of the emergencies often require facilities available at hospitals.
3. Changing patterns of health care have increased the need for emergency room service.

The study, first of its kind in the United States, covered emergency room care in 22 Michigan hospitals during a seven-day period in January 1965. Besides analyzing 3,650 hospital case records, the study involved extensive data received from 540 patients, and indicated that the reasons given most frequently by patients for emergency room visits.

* * *

TABULATIONS REVEALED that 35 per cent of all patients were sent to emergency rooms by their physicians; 54 per cent did not attempt to contact a physician before going to emergency rooms, and 11 per cent said they tried to call their physicians but could not reach them.

Noting both the rapid rise everywhere in the number of emergency room visits, and the expected 100 per cent increase in the decade that began in 1960, the report said that "non-emergency cases are appearing with greater frequency and are creating indecision over how to plan and staff for additional facilities."

* * *

THE REPORT STATED that "The diagnosis recorded provides only a very rough indication of the urgency of the patient's condition; hence, it is impossible to say just how many were or were not emergencies."

Some hospital administrators and physicians advocate a return to the traditional concept of "the emergency room for emergencies only." This group frequently holds that prepayment plans and insurance encourage emergency room use; that increasing numbers of persons are without family doctors; that hospitals are more convenient for some patients; and that hospitals are, in effect, practicing medicine. They sometimes suggest a screening process through which some patients would be cared for and others would be referred to physicians' offices.

Others hold that the public has come to look at hospitals as community health centers where they may apply with any complaint, at any hour of the day or night, and expect prompt and courteous attention as their due. This group feels that this changed concept must be accepted as a community obligation by hospital governing boards, hospital administrators and the medical profession.

* * *

IN ITS SUMMARY of major findings, the report revealed that when patients were asked why they went to hospital emergency rooms —

46 per cent called a physician's office before going to the hospital and 35 per cent of all patients actually talked to a physician. In addition to the 46 per cent who attempted to call a physician, 23 per cent said they went to the hospital primarily because they believed their physicians were not available at the time care was needed.

23 per cent of all patients were treated in emergency rooms by their family physicians. In 19 per cent of all cases, physicians instructed patients to meet them at the hospital.

31 per cent of all visits occurred on Saturday or Sunday, and an additional 40 per cent occurred between 4 p.m. and 8 a.m. on weekdays. A disproportionate percentage of emergency conditions are treated at hospitals at odd hours when physicians are less likely to be available.

* * *

LESS THAN 1 per cent of all patients mentioned prepayment or insurance coverage as a reason for going to emergency rooms. Relatively few Blue Cross members used emergency room facilities to avoid out-of-pocket expense of a physician's office visit. It appears . . . that financial motives were not an important factor.

Only 5 per cent of all patients named convenience as the primary reason for choosing the emergency room.

The study revealed great variations from hospital to hospital in the characteristics of patient and in the reasons for emergency room visits.

List Nine Stops For Healthmobile

School children, parents, teachers, students of history, paramedical workers, et al, are singing the praises of the MSMS Heathmobile.

The reception to the handsome MSMS Healthmobile, dedicated at the MSMS Centennial Session, has been enthusiastic. The cooperation of the local county medical society, the auxiliary members, mass media, schools, merchants, and others has surpassed expectations.

Open free to the interested public, the Healthmobile has traveled from Lansing to Flint to Pontiac to Jackson to Battle Creek to Coldwater and to Hastings.

Inasmuch as possible, the Healthmobile is being routed into a community during the week requested by the county medical society. Following are the names of the sponsoring societies and dates for the next several months:

Washtenaw	**Jan. 14-21**
Lenawee	**Jan. 21-28**
Wayne	**Jan. 28-Feb. 4**
Macomb	**Feb. 4-11**
St. Clair	**Feb. 11-18**
Sanilac	**Feb. 18-25**
Midland	**Feb. 25-Mar. 4**
Saginaw	**Mar. 4-11**
Bay	**Mar. 11-21**

A Monthly Commentary

Reporting As Ordered

By Hugh W. Brenneman
Executive Director

As they say in the jargon of Wall Street: "What is the mix for '66?"

Four big basic efforts of the MSMS are seen from the viewpoint of staffers at 120 W. Saginaw. The big four—Communications, Government, Administration, and Research and Development—wrap up most of the work of the Society as it seeks to unify all the diverse programs and interests of Medicine in Michigan.

Communications

The great bulk of the work of this Society is the collection and dissemination of *established* fact. The MSMS does not, directly, engage in original research in the medical sciences.

This collecting of facts might include information about various diseases or various kinds of medical treatment, or governmental health services currently and prospectively offered, or the latest governmental edicts that affect medical practice, or information re medical insurance, or etc., etc., etc. The dissemination of these facts is arranged via Annual Sessions, seminars, postgraduate courses, publications, radio programs, television programs, letters, meetings, etc., etc., etc.

Because the "collection and dissemination of facts" is a pretty good definition of communications, the philosophisizings above adds up to one fact, namely: that one of the biggest challenges the MSMS has is communications. During 1966 we can expect a redoubled effort on the part of both our scientific and socio-economic committees not only to adopt wise and forward-looking policies but to work mightily toward collecting and disseminating facts to the profession and the public. Staff help in the over-all communications effort will be headed by Herb Auer with strong assists from secretaries of the committees.

Government

For many years this profession has valorously fought against socialized medicine. We have heard no change in policy in that regard and expect none.

But to ignore the fact that government at all levels is involved in the purveying of medical care is to invite disaster. The avoidance of major losses to good medical practice—by the application of governmental mandates which are inherent in governmental programs—can only be accomplished by advisory action applied *before* the mandate is issued (or as a poor substitute by prompt objection immediately after the issuance).

This necessitates an alertness to both legislative efforts and governmental regulations far more sophisticated than we have had in the past. This is not said in derogation of past efforts . . . quite the contrary, it is from the success of these past efforts that the opportunity to be of influence still prevails.

Governmental policy is important. The hard, gut, work that promises success consists of being present *with the facts* when the moments of truth arise.

Several committees work in this area, i.e., the Legal Affairs Committee, Advisory Committee to the State Executive Office, the various other liaison committees with governmental agencies, and particularly the new Committee on Governmental Medical Care Programs. Mike Riley will head staff effort in this category and new staff personnel will be added to deal particularly with governmental agencies.

Administration

Today you can't get places fast enough on foot. You need a rocket capsule, a jet plane or a fast car; i.e., a vehicle designed to transport you to a particular destination in the most rapid, efficient, safe and (hopefully) comfortable fashion. The MSMS is that vehicle for the medical profession in this state.

This vehicle has to have income, secretarial and stenographic production, housing, accounting, travel, office machinery, etc., and it all has to jibe. The daily grist of repairs, upkeep of the headquarters, the important work of production and mailing of letters, the recognition and certification of membership, the handling of committee minutes, the implementation of direct instructions of the official family are reviewed each month by The Council and its standing committees, particularly the Advisory Committee to the Executive Director. These staff functions are headed by Associate Executive Director Warren Tryloff.

Research and Development

Much has been done in professional reorganization research and development. MSMS has for years pointed with pride to its Michigan Firsts, most of which were organizational activities; e.g., the development of the Michigan Health Council, the organization of the Michigan Association of the Professions, and before that, much original work

(Continued on Page 45)

Flagyl destroys trichomonads
here & here & here & here
No topical treatment can

Flagyl®
brand of
metronidazole

Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection.

These difficulties arose mainly from:

1) the failure of any previously known agent to destroy the protozoan in paravaginal crypts and glands;

2) the failure of any previously known agent to prevent reinfection by eradicating the disease in male consorts.

The introduction of Flagyl removed both of these long-standing deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced a cure rate of up to 100 per cent in large series of patients.

Nothing cures trichomoniasis like Flagyl.

Dosage and Administration

In *women:* one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.

In *men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

Contraindications

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

Dosage Forms

Oral—250-mg. tablets/Vaginal—500-mg. inserts

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Research in the Service of Medicine

An antibiotic of choice is one that works

TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

The Plus...Consistent Performance

Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

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[triacetyloleandomycin]

J. B Roerig and Company, New York, New York 10017
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TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylocci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions**: TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References**: 1. Isenberg, Henry D.: Health Laboratory Science **2**:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine **70**:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science **1**:185-256 (July-Aug.) 1964.

REPORTING AS ORDERED/continued

leading to the organization of the various health associations such as the Michigan Heart Association, the Michigan TB Association, and the national Conference of Presidents and Other Officers of State Medical Associations, Michigan Medical Service and even the Michigan Department of Health.

Research and development in organizational techniques, a logical corollary, has proceeded apace in Michigan, too. The Centennial, the Healthmobile, the beautiful headquarters building, the various campaigns—Measles, Get-Out-The-Vote, MichPac, the Michigan Minutemen, etc.—are sample proof of the alertness of MSMS to the development of new and better organizational techniques. Also Michigan was one of the first states to retain good advisory counsel in Law, Public Relations, Economics, Accounting, etc.

Sometimes as though they were in an impenetrable haze the big issues of the future loom up—indistinguishable, yet having the promise of solidity; impenetrable, yet having indicative shape. It is vitally important if we expect future progress to relate past experience to the issues of the future.

It is not impossible to do some advance planning if the necessity for research and development is understood:

(1) Can we agree that it is necessary to find the objectives of the MSMS, review them, revise them, and redefine them if necessary?

(2) Would you concur that this profession must keep its uniqueness by its members constantly being even better qualified to practice medicine than anyone else?

(3) Isn't it necessary for the profession to maintain a high reputation — a "favorable image"?

(4) Does anyone doubt that standards of the profession will change—or that the profession should do the changing?

(5) Is there agreement that the medical profession must help to: regulate itself, continually "reform" itself, turn scientific theory into medical practice, specialize without weakening, generalize without diminishing progress, continue its professional education, relate itself favorably to sub-professions, other professions, business, etc.?

This type of research and development planning can be done during 1966 by the profession, by the House of Delegates of MSMS, The Council, and with the help of its advisors in Law, in Economics, in Education, in Financing.

At least for the moment I'm going to try to staff this effort myself with the help of Les Dodd, Clyde Hardwick, Robert White, Warren Tryloff, et al.

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

February 27, 28-March 1, 2, 1966

Palmer House, Chicago

THIS CONFERENCE WILL BE OF INTEREST TO ALL PHYSICIANS

It will be presented in a manner designed to interest the generalist and specialist alike. *THE PROGRAM IS PRESENTED BY TYPES OF DISEASE ENTITIES, NOT SECTIONALIZED BY MEDICAL SPECIALTIES.* All physicians, regardless of their field of interest, will find this program to be informative and useful.

For program or registration information address:

Clinical Conference Committee
Chicago Medical Society
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Chicago, Illinois 60604

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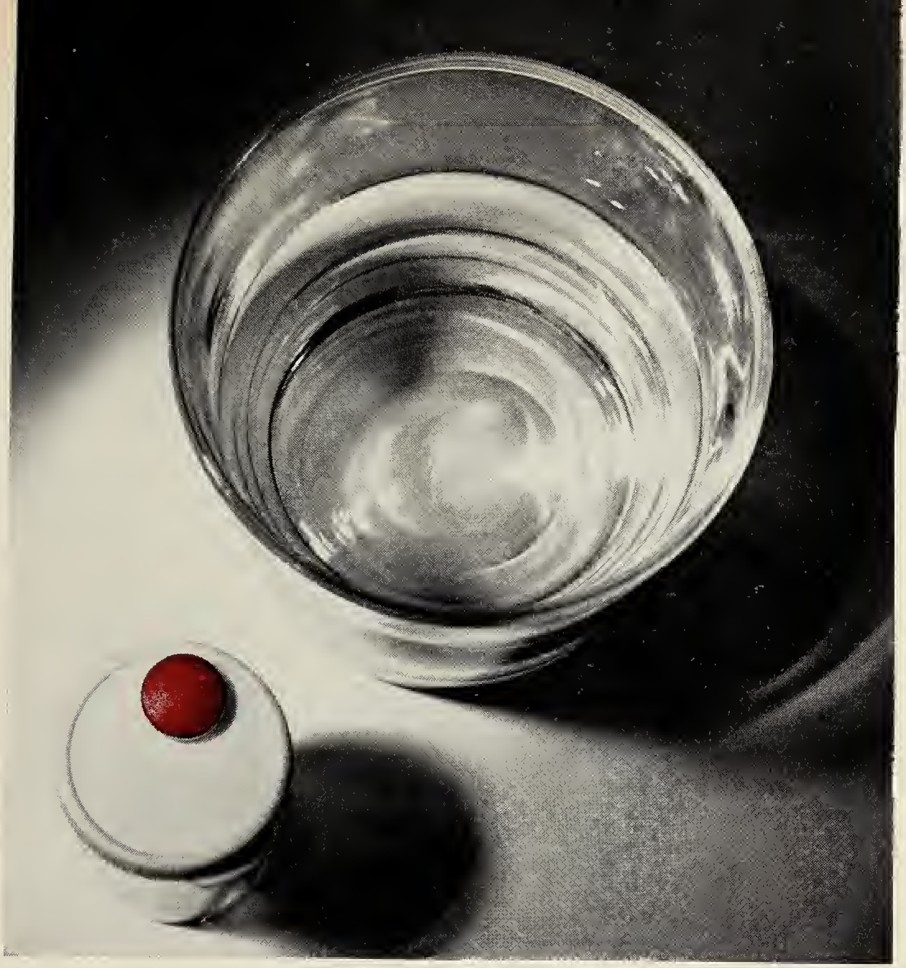

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vhen the offending organisms are tetracy-
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le effects typical of tetracyclines include
ssitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely, anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

Tablets: 300 mg of demethylchlortetracycline HCl.

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6555-2355

SOCIO-ECONOMICS

Explains Figures Used in Erratic Numbers Game

By Richard M. Campau
MSMS Research Director

James Z. Appel, M.D., President of the American Medical Association, recently called the attention of American physicians to the "Erratic Numbers Game" being used for the international interpretation and comparison of health statistics.

Instead of applying statistics objectively to disease problems, certain critics are whetting them into weapons intended to discredit medicine as we know it. Their chief barb being the contention: "America is not the healthiest nation on earth. Statistics prove American medicine to be inferior to that practiced in certain European countries." Understandably, American physicians are not taking kindly to the goading.

The charge that American medicine must take a back seat to foreign medicine most often is based on just two of the numerous statistical tables which appear in the United Nations' *Demographic Yearbook* (which catalogs the world's population, birth rate, marital status, and manner in which people die). One denotes life expectancy; the other, infant mortality rate.

* * *

SINCE THESE FIGURES do show that in America the infant mortality rate is higher and life expectancy somewhat less than in England, Sweden, and certain other small countries, this is offered as proof positive that we have inferior medicine. On the surface it looks like a compelling argument, but perhaps only because *so much is left unsaid.*

Consider the following:

1. Data collecting systems, their reliability and interpretation, vary from country to country. A child born with a beating heart but without the strength to breathe would be considered an infant mortality in the United States. In Sweden, such a child would be listed as a stillbirth, and not reflect on their infant mortality rate.

2. A nation's laws are not included in statistical reports. In some nations, a baby is not legally born alive until his birth is registered with civil officials or he is baptized. If the child dies before these technicalities are accomplished, this is not considered an infant mortality since the child was not "legally born alive."

In countries where abortion is legal, a defective

Doctor, *DID YOU KNOW...*

that the Michigan State Medical Society sponsors the following Group Insurance Plans for its members:

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Death & Dismemberment up to $100,000

Long Term Disability

Professional Overhead Expense

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Lansing, Michigan 48903

etus can be destroyed before birth, which has the ffect of lowering the infant mortality rate.

3. Longevity is to some extent an inherited trait, nd the extended life spans of the Swedes may nerely attest to this fact. It is a matter of record, owever, that a Swede in Minnesota outlives a wede in Sweden.

4. Available data on the possible effect of climate n life-span can show that while the average Engishman lives about half a year longer than the verage American, those Americans living in a limatic belt roughly equivalent to England's live ust as long, in fact, perhaps a little longer.

5. Finally, it should be noted that some nations mit data on minority races living within their oundaries.

Even if it were possible to shuffle and adjust inant mortality and longevity figures to take into ccount genetics, climate, the law, and reporting ystems, it's still not certain whether you would ave a yardstick for measuring medicine. Cerainly, you can't gauge a nation's medicine without onsidering its medical progress. No nation can natch the United States in terms of progress.

* * *

STATISTICS, of course, are important. Used roperly, they can lead to valid conclusions. Used improperly, however, they can "prove" any preconceived conclusion. Nevertheless, the assault by figures goes on as if there were no reality and no meaning except what can be wrung from this chart or that table.

A statistic is a fact—the result of a survey—and that's all it is. Conjectures made on such a statistic are not facts. They are conjectures. Statistics are a complement, not a substitute, for trained intellect and common sense. They pose questions, they don't answer them. They are slaves, not masters.

It seems to be a phenomenon of our time that all that is necessary to prove your point is to preface it with the magical words: "According to statistics . . . ."

MORE ON NUMBERS GAME

In 1920, the charge for a house call by a physician was $3-$5. By 1961 the average had raised to $7-$10. During the same period, the price of potatoes went from 39c per bushel to $5.40 per bushel. Yet we hear few complaints about the present price of potatoes. They are quoted now as five pounds for 45c. The bushel price is avoided. The psychology is much better.

—*Nebraska State Medical Society*

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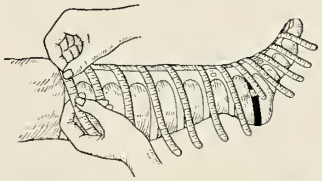
no two legs are alike

That's why "off-the-shelf" support garments cannot be expected to successfully apply correct counter pressures to the hydro-static column of the limb. Correct counter pressures can only be supplied by a true Venous Pressure Gradient Support which has been custom made and individually engineered. Your Jobst Service Center is staffed by experts who will precisely measure and fit your patient according to your prescription. For prescription blanks and clinical data, phone or write: Jobst Service Center, Suite 426 Fisher Building, 3001 W. Grand Blvd. Phone: 875-3808 Detroit, Michigan 48202.



Only JOBST Supports are custom made from precise measurements of the individual extremity.

Serve Community And Profession

The **Manistee County Medical Society** has donated $600 to the Swimming Pool Association toward the cost of a pool feasibility survey. The survey will deal with pool locations, financing methods, etc. A Chicago firm has been contracted to make the study.

Physicians and clergymen joined for a November program at Marquette to hear a Chicago hospital chaplain discuss the need for greater understanding between the two groups. A panel discussion followed. Donal Conley, M.D., and David Wall, M.D., of the **Marquette-Alger County Medical Society** were on the panel.

A Diabetes Detection Campaign was conducted by the **Calhoun County Medical Society** during November. Robert E. Fisher, M.D., was the campaign chairman. The tests were done free of charge in the physician's offices.

Gratiot-Isabella-Clare County Medical Society gave the Pap test to all interested women over 21 during a November campaign, for only the cost of an office call.

A series of health tests were offered during the fall by the **North Central Medical Society** for residents.

The Washtenaw County Medical Society in November was host to the wives and also to the University of Michigan Chapter of SAMA and its Auxiliary, the WASAMA.

Information about the 17th **Genesee County Medical Society** Cancer Day, April 6 at Flint, appears on the Ancillary Meetings page.

Henry J. Meyer, M.D., back in 1902 received the charter for the **Saginaw County Medical Society** from MSMS when Doctor Meyer was the county society president. He recently participated in a program of the county society when a copy of the original charter was relayed from MSMS to Edwin M. Wright, M.D., the current president.

Eleven senior physicians were honored recently by the **Kalamazoo Academy of Medicine.** C. Howard Ross, M.D., Ann Arbor, member of the MSMS Geriatrics Committee, was the speaker.

Genesee Cancer Day Lists N. Y. Authorities

All MSMS members are invited to attend the 17th Cancer Day Program of the Genesee County Medical Society at Flint, April 6. The program will be an all-day affair at the Merliss Brown Auditorium of the Hurley Hospital, from 9:30 a.m. until about 5 p.m.

Max E. Dodds, M.D., Chairman, reports that speakers will include two authorities from New York. Arthur I. Holleb, M.D., Associate Medical Director, Memorial Hospital for Cancer and Allied Diseases, New York City, will discuss "Unusual Problems of Breast Cancer," and Avery A. Sandberg, M.D., Chief of Medicine, Roswell Park Memorial Institute, Buffalo, will talk about "Chromosomes and Cancer."

Interested physicians may obtain further information from Doctor Dodds, Genesee County Medical Society, 806 West Sixth Avenue, Flint 48503.

* * *

BATTLE CREEK—About 50 organizations sent representatives to an evening Community Mental Health Services program sponsored recently by the Calhoun County Medical Society and its Auxiliary.

The alcoholic
CAN be rehabilitated

With a unique background of 80 years' experience, The Keeley Institute has earned an international reputation as a specialized hospital for the *restorative treatment* of the "problem drinker."

Our progressive, well-rounded regimen includes:

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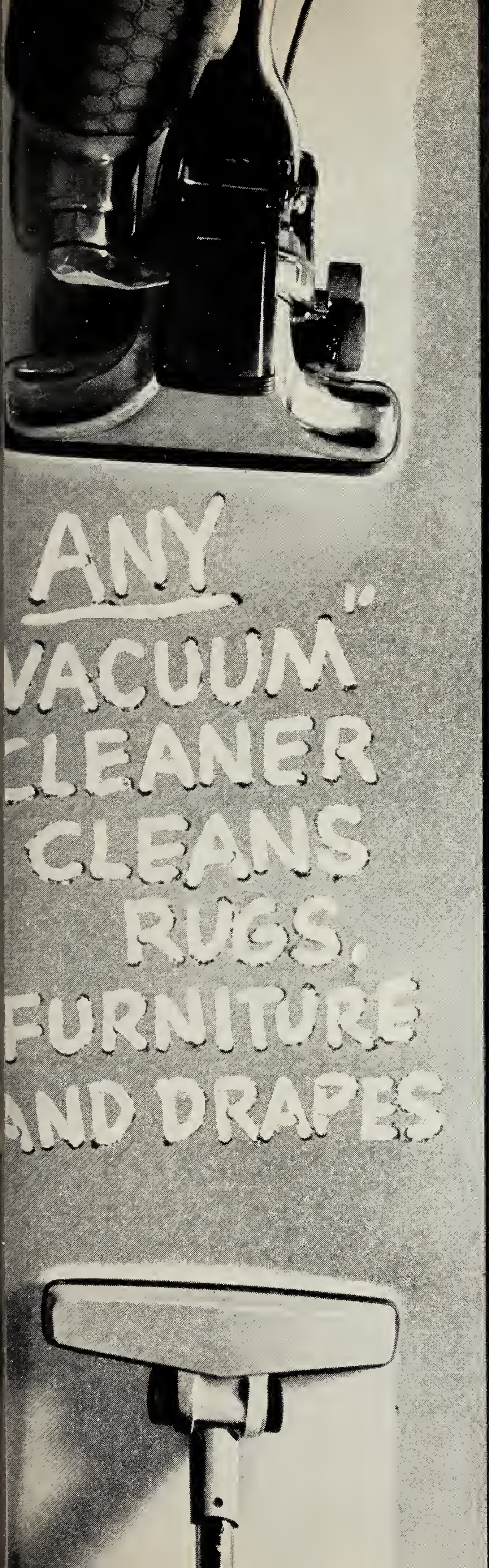
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CLEANS
RUGS,
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AND DRAPES

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Filter Queen cleans the air, too!

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Proof? See inside—

DRAMATIC TEST PROVES FILTER QUEEN TRA

FILTER QUEEN

1 Place a fresh Sanitary Filter Cone in the FILTER QUEEN container. (It takes only a moment to open the machine and replace the old Filter Cone.)

2 Now unfold a clean white handkerchief and drop it into the Sanitary Filter Cone. (Even the daintiest, sheerest handkerchief may be used with perfect safety.) Then replace the turret top on the container.

3 Now turn the machine over to any on witnessing the demonstration, and have he start the machine and apply the nozzle to an place where there is obvious dirt and dust Keep the machine operating for a full minute

See the proof with the FILTER QUEEN *"clean handkerchief" test*

4 Remove the top of the container, and lift out the handkerchief. You'll find it spotless as it was when it went in! (Where did the dirt go? Look in the bottom of the container.)

FILTER QUEEN
FILTER QUEEN

NO DUST ON HANDKERCHIEF

filter traps dirt in container

DUST AS NO "VACUUM CLEANER" CAN!

Revolutionary...and in a class by itself!

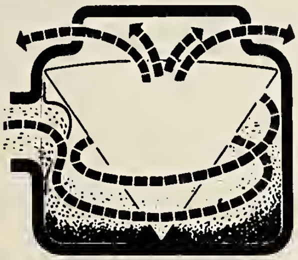
FILTER QUEEN

has the scientific cleaning features that hospitals need most

All "vacuum" cleaners were much the same until the FILTER QUEEN SANITATION SYSTEM was designed. FILTER QUEEN'S patented Sanitary Filter Cone eliminates the need for messy bags, traps practically all airborne contaminants passing into the machine (Harvard Medical School Report in Journal of the American Medical Association, November 25, 1958).*

Experienced hospital housekeepers know this well. That is why FILTER QUEENS have replaced every type of vacuum cleaner in hundreds of hospitals throughout the world.

FILTER QUEEN has no porous bag that permits dust and dirt to reenter the room. FILTER QUEEN operates on an entirely different principle, "Cyclonic Cleaning Action." Here's how it works: Inrushing air, laden with dirt and dust, is deflected by a patented inlet guide as it enters the container; then is whirled by centrifugal force away from the cone. Dust and dirt are dropped to the bottom of the container. (See illustration.) Air, being lighter, is funnelled to the center of the "cyclone," filters through the Sanitary Filter Cone and returns to the room dust-free.



Why not ask your local FILTER QUEEN Distributor to make the dramatic handkerchief test (pictured at left) in your hospital? There is no better way to prove the improvement in cleaning ability between a FILTER QUEEN SANITATION SYSTEM and any type of vacuum cleaner. (You'll find your distributor listed in the Yellow Pages; or write Health-Mor, Inc. direct).

What hospital administrators say about FILTER QUEEN

"I heartily recommend to any hospital administrator who is presently unhappy with the type of cleaning machine in use, that he try FILTER QUEEN for only two days and the machine will sell itself."

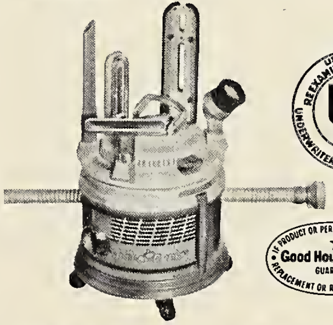
"The FILTER QUEEN is great—a very important factor in patient areas, and is constructed so as to prevent air turbulence of dust at floor level. Filtering of the air, while in general operation, is also a very important and desirable factor."

"One of the most pleasing features of the machine is its quietness. We can even clean in the rooms while occupied by the patients, and many have commented on how pleasant it is not to be disturbed by noisy, old-fashioned vacuum cleaners anymore."

"The air exhaust at the top of the unit is a wonderful feature, and the Sanitary Filter Cone is certainly our answer for working in closely confined patient areas."

"We thought we had a clean hospital and a fairly good method of achieving acceptable sanitation, but this little machine made us revise our thinking and our methods."

"A quiet motor which possesses excellent cleaning power and the convenience of having to clean out the cleaning compartment only once a month, has proved very advantageous. One of the most important points . . . is that there is no bag to empty."



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Heart Days Soon; Dr. Zoll Coming

The Michigan Heart Association's Annual Heart Days, February 25-26, at the Sheraton-Cadillac Hotel, will feature Paul M. Zoll, M.D., of Beth Israel Hospital, Boston, innovator in the case of electric shock in cardiac therapy and one of the inventors of the pacemaker.

The Scientific Sessions from 9 a.m. to 5 p.m., Saturday, February 25, will be opened by James B. Blodgett, M.D., president of the Heart Association. The program, which carries five credit hours from the American Academy of General Practice, follows:

9:15-9:45 a.m.—"Auscultation in the Assessment of Acquired Valvular Disease," W. Proctor Harvey, M.D., Georgetown University, Washington, D. C.

9:45-10:15 a.m.—"The Electrical Control of the Heart Beat," Doctor Zoll.

10:30-11:00 a.m.—"Pacemakers and Their Problems," William M. Chardack, M.D., Veteran's Hospital, New York.

11:00-12:00 Noon—Panel: "Treatment of Heart Block," Moderator, Richard D. Judge, M.D., University of Michigan; Panel Members, Joe D. Morris, M.D., University of Michigan; Rodman Taber, M.D., Ford Hospital, Drs. Chardack and Zoll.

2:30-3:00 p.m.—"Experiences in the Surgical Treatment of Acquired Aortic Valve Disease," Dwight C. McGoon, M.D., Mayo Clinic.

3:00-3:30 p.m.—"The Internist's Role in Heart Valve Prosthesis," Herbert E. Griswold, M.D., University of Oregon.

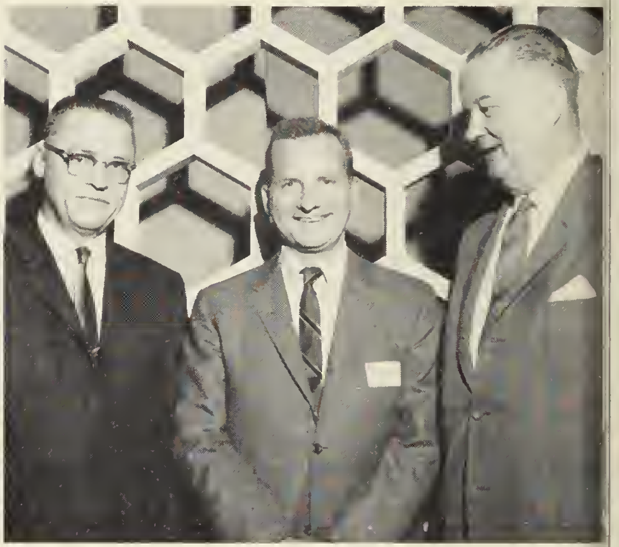
4:00-4:30 p.m.—"Surgical Treatment of Coronary Artery Disease," Donald B. Effler, M.D., Cleveland Clinic.

4:30-5:00 p.m.—Panel: Grand Surgical Summary, Moderator, Conrad R. Lam, M.D., Ford Hospital; Panel Members, Drs. Harvey, Griswold, McGoon, and Effler.

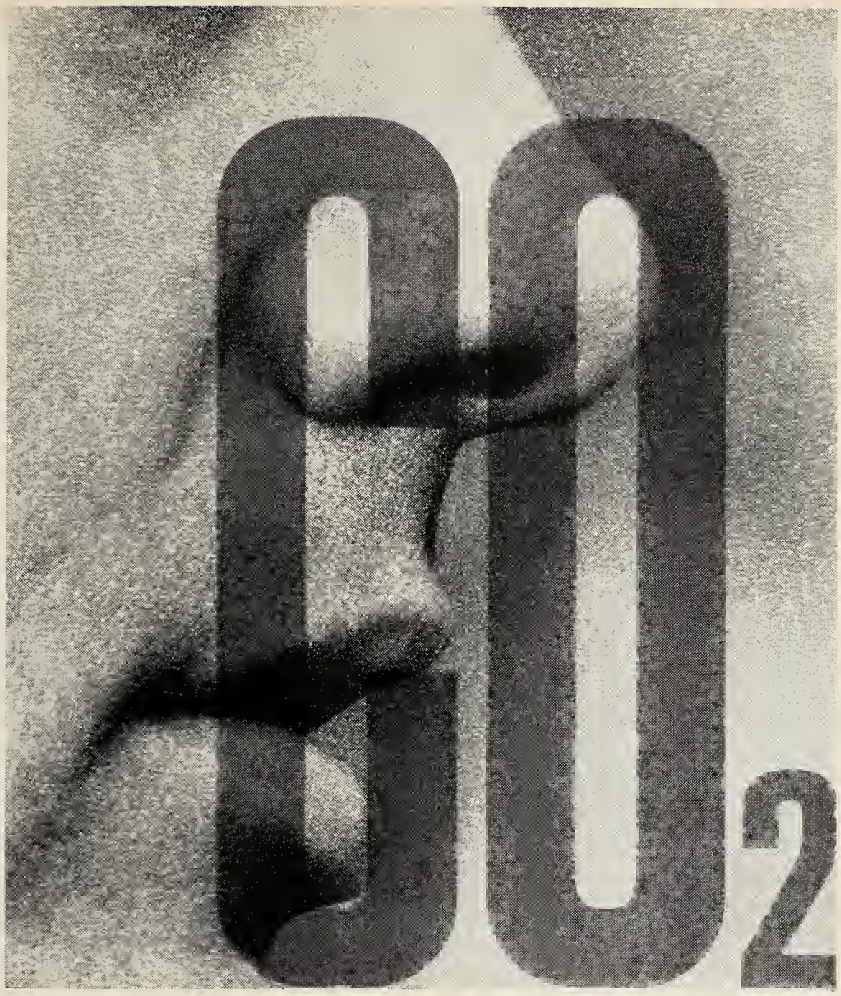
Speakers on the Coronary Care panel at 1:00 p.m., Friday, February 25, will be Clarence A. Imboden, M.D., Deputy Chief, Coronary Section, Heart Disease Control Program, U. S. Public Health Service, Washington, D. C.; Lawrence E. Meltzer, M.D., and Miss Rose Pinneo, R.N., M.S., both of Presbyterian Hospital, Philadelphia; and Ernest W. Reynolds, Jr., M.D., associate professor at the Heart Station, University of Michigan Medical Center. Moderator will be Jack M. Kaufman, M.D., Huntington Woods.

Dr. Meltzer and Miss Pinneo, with J. Roderick Kitchell, M.D., are the authors of a book, Intensive Coronary Care, published by the Coronary Care Unit Fund of Philadelphia.

The third annual special classes in Closed Chest Cardiac Resuscitation with movies, lectures, and practice mannikins, will be available all day Friday and Saturday.



"Well worth waiting for" sums up the enthusiastic audience reaction accorded the address on "Sick People in a Troubled World" by Howard Rusk, M.D., right, at the banquet during the WSU Stroke Symposium in Detroit. Dr. Rusk, director of the Rehabilitation Institute in New York City, was delayed by a flight cancellation and forced into making stand-by reservations to get to Detroit. Greeting him on his arrival were Ernest Gardner, M.D., left, WSU dean, and John Stirling Meyer, M.D., professor and chairman of the WSU Department of Neurology, who was in charge of the symposium. The three-day meeting attracted more than 250 physicians from the United States and Canada. It was sponsored by the Bureau of State Services, Neurological and Sensory Disease Service Program, U.S. Public Health. Speakers included Michael F. DeBakey, M.D., professor of surgery at Baylor University College of Medicine.



for patients behind the CO_2 curtain

The lethargic hypoventilators
Hypoventilators may be drowsy and lethargic when they must be awake and alert. The reason: retention of excess CO_2 in the alveoli and blood caused by impaired ventilation with respiratory depression. Most frequent hypoventilators are patients with pulmonary emphysema, extreme obesity, chest cage abnormalities, or cardiopulmonary disease.

EMIVAN helps overcome symptoms of CO_2 depression
Emivan increases depth of breathing and rate, when depressed, so that the lungs "blow off" excess CO_2, and oxygen tension is restored toward normal. As the CO_2 tension falls, symptoms of lethargy, somnolence, fatigue, and irritability abate. Emivan is safe to use: side effects have rarely been observed with oral Emivan (although with overdosage, it may sometimes cause wakefulness); there has been no evidence of toxicity.

Side Effect: Wakefulness at night which responds to reduction in dosage. *Precautions:* Emivan is a ventilatory adjunct to other therapeutic measures; its effectiveness is dependent upon an unobstructed airway. Courses of administration should not exceed eight weeks at a time. An apparent additive stimulant effect between Emivan and MAO inhibitors necessitates adjustment of dosage of either or both drugs when one is used in the presence of the other. *Contraindication:* Known or suspected epilepsy.

Consult product brochure for dosage and full information.

Available: 60 mg. tablets for oral administration; bottles of 100. Also 20 mg. tablets, bottles of 100.

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Towsley Urges Supportive Teams For Pediatricians

Proposals to train students as supportive teams for pediatricians were made by H. A. Towsley, M.D., Ann Arbor, at the 1965 convention of the American Academy of Pediatrics in his outgoing address and news interview.

The plan, it was explained, could spread child specialists' services to care for a child population growing at a far greater rate than the medical profession.

Doctors would delegate a number of duties to their supportive teams.

Young persons serving on the teams would be trained as laboratory technicians, pediatric and practical nurses, social workers, psychologists and teachers. Some would be trained to give hearing and eye tests, but for screening purposes only.

All would be directed by a doctor who would be responsible for the total health care of the child patient.

Dr. Towsley said various committees of the academy would begin studies on the idea of supportive teams and would confer with educators and other medical branches seeking co-operation to recruit and train students, beginning in high school.

One of the recent Michigan Health Council television programs over WWTV at Cadillac included Tom Tresh, at left, New York baseball star and an off-season student at Central Michigan University. The program on "Paths to Fitness" also included left to right, Thurman Walrod, WWTV; Ed Rice, Michigan Department of Public Instruction, and John Doherty, executive director of the Health Council.

PG Offerings Up 50% in Nation

Most physicians continue to study medicine long after entering practice—and the number of postgraduate medical courses available to them has increased nearly 50 per cent in the past five years.

The annual report on medical education by the AMA's Council on Education reports that the number of physicians registered in these courses may be over 150,000.

Formal postgradaute courses, however, are becoming increasingly important. Medical schools continue to be the major sponsors, but courses also are offered or co-sponsored by medical societies, voluntary health agencies, hospitals, and governmental health agencies.

Attending courses, however, is only one of the ways a doctor continues his education, the report points out. Most physicians rank their continued reading of medical literature as one of their most important sources of new knowledge. They also continue their education through professional contacts with other physicians, and through hospital staff meetings and national state and local medical society meetings.

Medicine Department Head Named at MSU

Alfred Jay Bollet, M.D., formerly at WSU from 1955-1959, will return soon to Michigan as chairman of the new MSU College of Human Medicine Department of Medicine.

An authority on arthritis, Doctor Bollet will be leaving the University of Virginia where he is professor of internal medicine and director of rheumatic disease research and training program and chronic disease program. A past president of the American Federation for Clinical Research, he has his M.D. degree from New York University.

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pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of
moderate to severe
hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.

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EUTONYL™
25 mg PARGYLINE HYDRO CHLORIDE
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Tablets (Grooved)
ENDURON™
METHYCLO-THIAZIDE
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Each Eutron tablet contains two proven antihypertensives in the ratio shown to be most effective in most patients.

TM—TRADEMARK

New **EUTRON** extends your range of treatment in moderate to severe hypertension

A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

512214

1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.
2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.
3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.

BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.

The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week – maximum reduction in seven to ten days.

Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

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ocial Security ata for Doctors:

(Editor's Note: Following is important informa- on to physicians about the new aspects of Social curity. It will be valuable as physicians complete ederal Individual Income Tax Returns.)

ocial Security r Self-Employed Physicians:

Taxable years ending on or after December 31, 65—As a self-employed physician you must com- ete Schedule SE of your Federal individual in- me tax return to include your earnings in profes- onal self-employment and pay the self-employ- ent tax. Your net earnings will be counted toward ocial Security benefits for you and your family for y year in which they amount to $400 or more 6,600 maximum). Be sure that your Social Secur- y account number is shown correctly on the hedule SE. Your Social Security account number d taxpayer identification number are the same.

Contribution Rate Schedule for
Self-Employed Physicians
Per Cent of Covered Earnings ($6,600 maximum)

ears	For Old-Age Survivors, and Disability Insurance Benefits	For Hospital Insurance	Total
65	5.40%	.00%	5.40%
66	5.80	.35	6.15
67-68	5.90	.50	6.40
69-72	6.60	.50	7.10
73-75	7.00	.55	7.55
76-79	7.00	.60	7.60
80-86	7.00	.70	7.70
87 and after	7.00	.80	7.80

ocial Security or Interns and Residents:

January 1, 1966—Interns and residents working a Federal Hospital, or a privately owned hospital perated for profit, will receive Social Security redit for their professional salaries. If you are mployed as an intern or resident, be sure your em- loyer has your Social Security account number. f you are employed by a non-profit hospital (one xempt from income tax), or a hospital operated by state or local government, your wages will be covered only if arrangements have been made for the hospital employees to be covered. To find out if your earnings will count for Social Security, ask the people in your personnel office.

Contribution Rate Schedule for Interns
or Residents and Employers (Each)
Per Cent of Covered Earnings ($6,600 maximum)

Years	For Old-Age Survivors, and Disability Insurance Benefits	For Hospital Insurance	Total
1966	3.85%	.35%	4.2 %
1967-68	3.90	.50	4.4
1969-72	4.40	.50	4.9
1973-75	4.85	.55	5.4
1976-79	4.85	.60	5.45
1980-86	4.85	.70	5.55
1987 and after	4.85	.80	5.65

All for One Drug!

The time spent on developing just one new, effi- ient drug product—if only one person were in- olved in all the study and research—would require 9 working years—or 58,000 hours—of a research hemist's life.

Predict Increase By Aged in Demand For Hospital Care

The planning committee of the Greater Detroit Area Hospital Council has made estimates of the impact that the recently enacted Medicare legislation will have on area-wide planning and health facilities.

As it related to acute care, the Committee believes that patients over 65 years of age who presently utilize approximately 25 per cent of the patient days will increase their demand by 10 to 20 per cent. Overall, this would increase the demand for acute general hospitals by 2½ to 5 per cent.

In view of construction underway, or approved and soon to be underway, which will increase present bed supply by approximately 12 per cent, it is believed that the hospital community will be able to adjust adequately to the increased demand. The Committee contends this, however, will depend largely upon two assumptions—one, that reasonably effective utilization review will limit the use of the acute general hospitals to those patients whose medical conditions require such facilities; and two, the Federal Government develops some administrative mechanism whereby on January 1, 1967, when the nursing home benefits become available eligible beneficiaries then in nursing homes can be medically evaluated and declared eligible for nursing home care without being required to stay three days in the hospital for such evaluation.

With respect to long-term care facilities, no conclusions were reached.

The Pain Is Gone

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. ½ (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. ½.

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ARISTOCORT Topicals are particularly effective in controlling the inflammatory symptoms of many dermatoses including neurodermatitis, atopic dermatitis, eczematous dermatitis, seborrheic dermatitis and certain cases of psoriasis. The 0.1% Cream or Ointment is usually effective in abating symptoms of skin conditions responsive to topical triamcinolone, but the 0.5% Cream may be preferable in more resistant cases. *Dosage:* Apply small quantity to area 3 or 4 times daily. Side effects are rare. *Contraindications:* tuberculosis of the skin, herpes simplex, chickenpox, and vaccinia. Use with care on infected areas. Do not use in the eyes. Supplied in 5 and 15 Gm. tubes and ½ lb. jars. Also available in foam form and with Neomycin.

Aristocort® TOPICAL CREAM 0.1% AND OINTMENT 0.1%

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State Offers New Help for Draft Medical Rejectees

By Michigan Department of Public Health

To help ensure that medical rejectees get medical help, the Michigan Department of Public Health under a contract with the United States Public Health Service, is developing a state-wide counseling, referral, and follow-up service for those rejected for military service for medical reasons.

This program is part of a national effort resulting from recommendations of the Task Force for Manpower Conservation, appointed in 1963 to study the problem.

In Michigan, 45 per cent of those called up in 1964 for service in the Armed Forces were rejected; 29 per cent for medical reasons, 16 per cent for mental reasons.

In other words, almost half of the young men of Michigan were not deemed fit for military service. Obviously, some of these rejectees were not considered fit for reasons which are not amenable to effective treatment. However, it is estimated that about 75 per cent of all medical rejectees would probably benefit from treatment.

The reasons for medical disqualifications are summarized in Table I.

* * *

THE SERVICE OFFERED to Michigan's medical rejectees is basically one of health counseling and referral for treatment. A basic tenet of the program is that these men with medical defects should be referred to a private physician. If referrals to other health resources in the community are needed, the private physician must be kept informed.

Another basic principle which is followed in Michigan is to avoid any implication that rejectees are being assisted only to make them available for military service. In fact, there is no requirement and no intention to report the correction of defects to the draft board. The basic purpose of the program is to help these men become healthy and contributing members of their communities.

* * *

THE PROCEDURAL model which has been adapted for Michigan is as follows:

1. Immediately after the man has been rejected by the Detroit Armed Forces Examining Station, he will be referred to a Michigan Department of Health counselor located at the examining station. He will be interviewed briefly, primarily to convince him to accept the counseling assistance which will be available to him when he returns to his home. At this point, he will be asked to sign a voluntary waiver, which allows authorized health department personnel access to his medical examination record.

2. After the young man has been interviewed and signed the waiver, he will be referred to the local health department which serves his home area.

3. The local health department will then contact the rejectee to arrange for health counseling and referral to the appropriate medical and/or rehabilitation resource for care of his defect or handicap. If it is found that the young man is already under medical care, further counseling will be conducted only after consultation with the individual's physician.

If the rejectee is not under medical care, the local health department representative will attempt to

TABLE I

Reasons for medical disqualification: by diagnostic category and frequency of defect per 10,000 medical rejectees*

Orthopedic	1,571
Psychiatric	1,223
Circulatory	1,008
Eye	974
Anthropometric	650
Ear and Mastoid	628
Digestive	581
Allergic	557
Infective and Parasitic	467
Neurological	454
Congenital Malformations	376
Endocrine	223
Neoplastic	199
Skin and Cellular Tissue	175
GU System and Breast	139
Respiratory (non-TB)	118
Blood and Blood-Forming	26
Metabolic and Avitaminoses	19
Miscellaneous	612

*Source: Bernard D. Karpinos, "Qualification of American Youth for Military Service," Medical Statistics Division, Office of the Surgeon General, Department of Army, 1962.

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Edema, danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile, or when other potent drugs are given concurrently. Large doses are contraindicated in patients with glaucoma.

Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently.

Dosage
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REJECTEES/continued

arrange for such care. After explaining to the young man the medical reason or reasons he has been disqualified, the need for treatment and/or rehabilitation services will be stressed. The rejectee will be encouraged to seek these services and will be offered assistance in making the initial contact with the appropriate physician or agency.

4. The local health department will also have the responsibility for making follow-up contacts to determine whether or not the rejectee in fact received or initiated the medical care and/or rehabilitation service for which he was referred.

* * *

THE PROGRAM in Michigan may have significant implications for the practicing physician, especially in view of the recent markedly increased draft calls. At the present rate, it would not be unreasonable to anticipate 30,000 medical rejectees per year in Michigan. Many of these young people will already be under medical care; however, the preinduction examination often uncovers conditions of which the individual is completely unaware.

In addition, many of the young men simply have not been motivated or able to seek appropriate medical attention in the past. It is, therefore, probable that a significant proportion of the total number of medical rejectees will seek care in their home communities.

It is difficult to assess the net effect of the program at this time; however, it would appear that certain benefits may result. First, an improvement in the level of health in the community through the correction of amelioration of medical defects in the young man of draft age. Also, by taking on this additional responsibility, the local health departments may increase their effectiveness in accomplishing basic objectives such as the study, prevention, and correction of health defects in the community.

* * *

AN ADDITIONAL benefit which could occur would be in the improvement of communication and cooperation among the medical care resources as they work together to assist these young men. While the program may initially add to the work load of physicians and other health and rehabilitation personnel, the long-range effect could well be a reduction in chronic adult disability.

Finally, if the program is effective, the major objective of manpower conservation may be met with resulting gains in productivity for local areas and the state as a whole.

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In Memoriam

Joseph W. Gething, M.D., Battle Creek

Joseph W. Gething, M.D., 93, retired physician of Battle Creek, died November 13 at his residence there.

A native of Battle Creek Township, he began medical practice in Battle Creek in 1903 after his graduation from Rush Medical College in 1901. He practiced two years at Elkhorn, Wisconsin, before returning to Battle Creek where he spent the remainder of his life. Doctor Gething retired from the active practice of medicine in 1957.

In 1962 Doctor Gething was honored by the Battle Creek Kiwanis Club with a 40-year membership certificate on his 90th birthday.

Doctor Gething was a Life Member of the Michigan State Medical Society and in 1951 received its 50-Year Award.

Allen R. Hennes, M.D., Detroit

Allen R. Hennes, M.D., professor of medicine at Wayne State University, died at Harper Hospital on November 23. He was 41 years old.

Doctor Hennes joined Wayne as an associate professor in 1961 and was named chief of the endocrinology and metabolism section. He also headed these units at Receiving and Harper Hospitals and was named a full professor three years ago. Doctor Hennes authored more than 60 professional and research articles.

Born in Benton Harbor, Doctor Hennes was graduated from the University of Michigan School of Medicine in 1949 and served his internship and residency in internal medicine at the University Hospital. He was an instructor and research fellow at U of M and served in the Navy during the Korean War.

Doctor Hennes joined the Brookhaven National Laboratory, Upton, N. Y., in 1956 and two years later became chief of radioisotope service at the Veterans Hospital in Oklahoma City. He also was chief of medicine there and assistant director of professional services and research.

Doctor Hennes' professional memberships included Alpha Omega Alpha, honorary medical society, the American College of Physicians and the American Board of Internal Medicine.

Zeno L. Kaminski, M.D., Detroit

Zeno L. Kaminski, M.D., Detroit physician for 46 years, died December 1 at Providence Hospital where he had been a medical staff member for 45 years. He was 77 years old.

Born in Detroit, he received a master's degree from the University of Detroit before completing medical school at Loyola University, Chicago, in 1916. Doctor Kaminski interned at Grace Hospital.

During World War I Doctor Kaminski served as an Army doctor in France.

Doctor Kaminski was a Life Member of the Michigan State Medical Society.

John R. MacGregor, M.D., Parchment

John R. MacGregor, M.D., industrial surgeon of Parchment, died November 12, 1965, in Borgess Hospital, Kalamazoo. He was 63.

Born in Midland, Doctor MacGregor received his medical degree from the University of Michigan and began practice in Kalamazoo in 1928. Doctor MacGregor was a past president of the Kalamazoo Academy of Medicine and served several years as physician for KVP Sutherland Paper Company in Kalamazoo. In 1945 he moved to Parchment where he practiced until the time of his death.

Doctor MacGregor was a member of the Michigan and American Associations of Industrial Physicians and Surgeon.

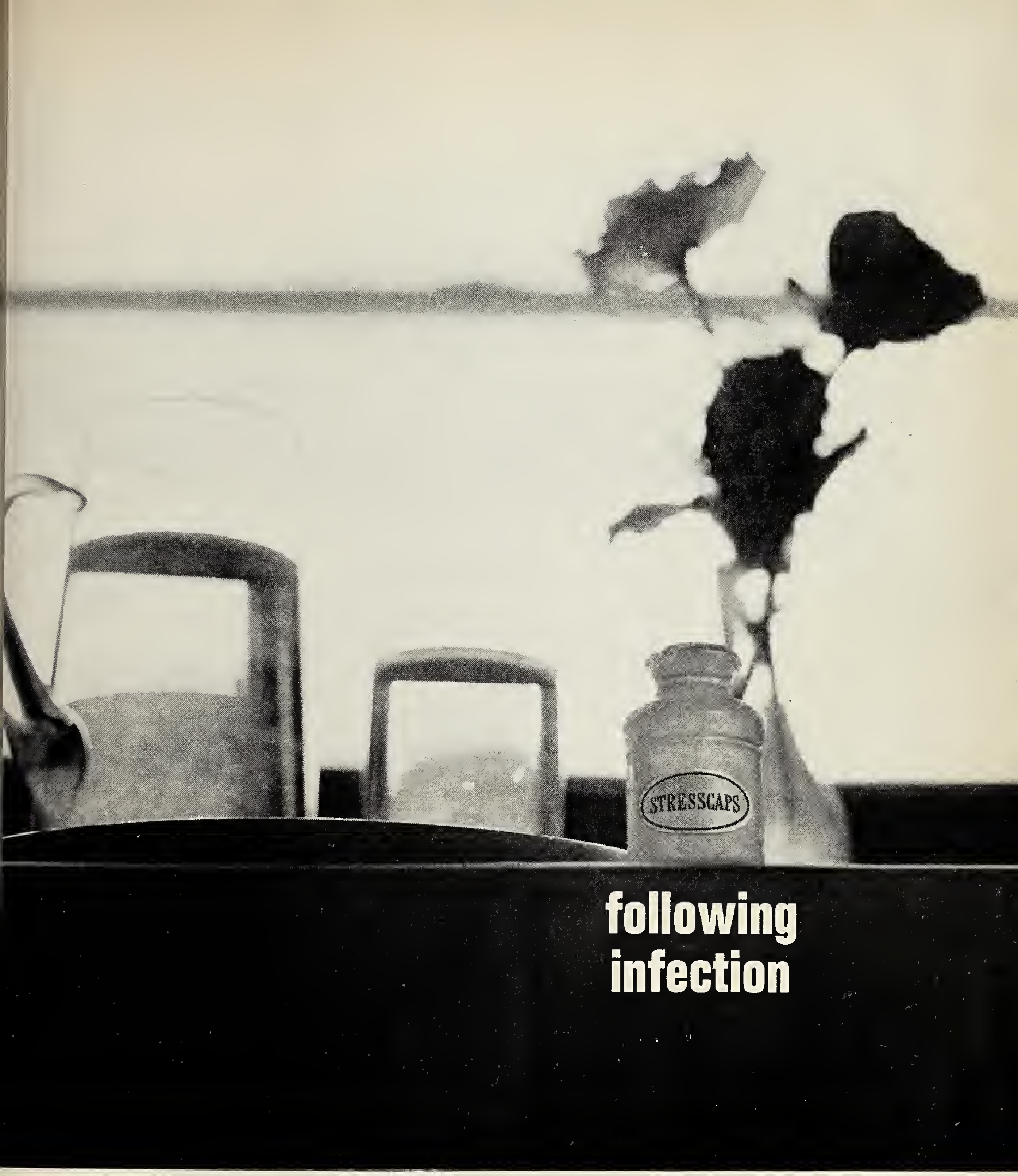
During World War II, Doctor MacGregor served in the Pacific as an Air Force captain for three and one-half years. He was a past commander of American Legion Post 332 in Kalamazoo.

Among the survivors is a brother, Robert MacGregor, M.D., of Ann Arbor.

Earl A. Peterman, M.D., Detroit

Earl A. Peterman, M.D., 65, Detroit physician and member of the Providence Hospital staff for 25 years, died November 5 at Ford Hospital.

Doctor Peterman was graduated from the University of Michigan Medical School in 1928. He



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was Medical Director at Woodward General Hospital, the Afflicted Infants Foundation, and a member of the board of directors of the Michigan chapter, Arthritis and Rheumatism Foundation.

Lula Belle Stewart, M.D., Detroit

Lula Belle Stewart, M.D., 45, Detroit pediatric cardiologist, died November 5 at Grace Hospital.

Named "Physician of the Year" in 1964 by the Detroit Medical Society, Doctor Stewart was honored on the "Showcase of Women in Medicine" program of the Lambda Kappa Mu Sorority. The Detroit branch of the Association for the Study of Negro Life and History honored her with a reception last February.

A native of Jackson, Mississippi, Doctor Stewart was a graduate of Meharry Medical College in Nashville, Tennessee, and received additional medical training at the University of Pennsylvania, Cook County Hospital of Chicago and Children's Hospital in Detroit. Doctor Stewart was on the teaching staff of Children's Hospital and Wayne State University.

Doctor Stewart was a fellow of the America College of Cardiologists, a Life Member of the National Association for the Advancement of Colore People and Delta Sigma Theta Sorority.

Herbert Wedel, M.D., Hastings

Herbert Wedel, M.D., medical director of th Barry County Medical Facility, died November at his home in Hastings. He was 69.

A past president of the Barry County Medica Society, he also served that organization as secretary.

Doctor Wedel received his medical degree fron the University of Michigan School of Medicine i 1928. He was affiliated with Pennock Hospital i Hastings.

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PERSONAL MENTION

A Distinguished Alumni Award was presented to **L. Dell Henry, M.D.**, Ann Arbor, at the fall homecoming at Shimer College, Mt. Carroll, Illinois.

The Tiffany Award of the Michigan Division of the American Cancer Society was presented to **H. Marvin Pollard, M.D.**, Ann Arbor, as an outstanding volunteer.

Abraham Becker, M.D., and **Max L. Lichter, M.D.**, were chairmen of a lecture program for **William Dameshek, M.D.**, Tufts, on behalf of the American Friends of the Hebrew University.

Kenneth P. Mathews, M.D., Ann Arbor, former president of the Michigan Allergy Society, has been named a member of the National Medical Advisory Committee of the Medic Alert Foundation International.

T. R. Cajigas, M.D., chairman several years ago for a major Careers Conference of the Michigan Association of the Professions at Traverse City, is now practicing in Bay City.

Herman Pinkus, M.D., Detroit, will speak at the New York University Medical Center Symposium on "Selected Aspects of Cutaneous Precancers, Cancers and Pseudo-cancers," April 27-29.

Jacques S. Gottlieb, M.D., Detroit, is a member of the Scientific Advisory Board for the new American Schizophrenia Foundation, concerned about research, treatment and public education re schizophrenia.

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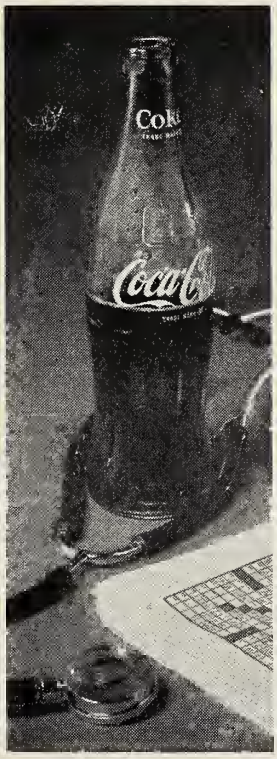

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Many of you know that I personally am deeply interested in brotherhood. And every physician is. With us, every week is Brotherhood Week.

In my address to the 1965 House of Delegates, I stressed that:

"All of us physicians treat all our patients alike, regardless of race, color or creed. It has always been that way. We also treat the growing number of foreign and non-white physicians in our state with the same regard that we treat our Caucasian peers. It is a pleasing note that more and more of these skilled men are being accepted on hospitals staffs, are attending continuing medical education courses and are participating actively in our county and state societies.

"We are remiss when we permit some to make slurs about medical men and women from other nations and from other races or to question our concern for their families in this country.

"Many of these foreign-trained physicians are choosing to become citize and residents of Michigan. We welcome them. We need them as we constan seek to obtain more physicians for our Michigan residents."

Those comments were from my heart in September and they are equa positive today.

In February, there will be considerable attention focused on Brotherho Month. All physicians and all Americans will be called upon to rededicate th lives to our democratic heritage of freedom and equality for all.

Three quarters of the people on our world belong to the eight major religions, which all have the same basic belief. It is well to restate them today as we see the need for greater racial and world understanding:

Brahmanism: "This is the sum of duty; do naught unto others which would cause pain if done unto you."

Buddhism: "Hurt not others in ways that you yourself would find hurtful."

Judaism: "What is hateful to you, do not to your fellow man. That is the entire law, all the rest is commentary."

Confucianism: "There is one maxim of loving kindness: do not unto others what you would not have them do unto you."

Taoism: "Regard your neighbor's gain as your own gain, and yo neighbor's loss as your own loss."

Zoroastrianism: "That nature alone is good which refrains fr doing unto another whatsoever is not good for itself."

Christianity: "All things whatsoever ye would that men should to you, do ye even so to them; for this is the law and the prophets."

Islam: "No one of you is a believer until he desires for his brot that which he desires for himself."

Luther R. Leader M.D.

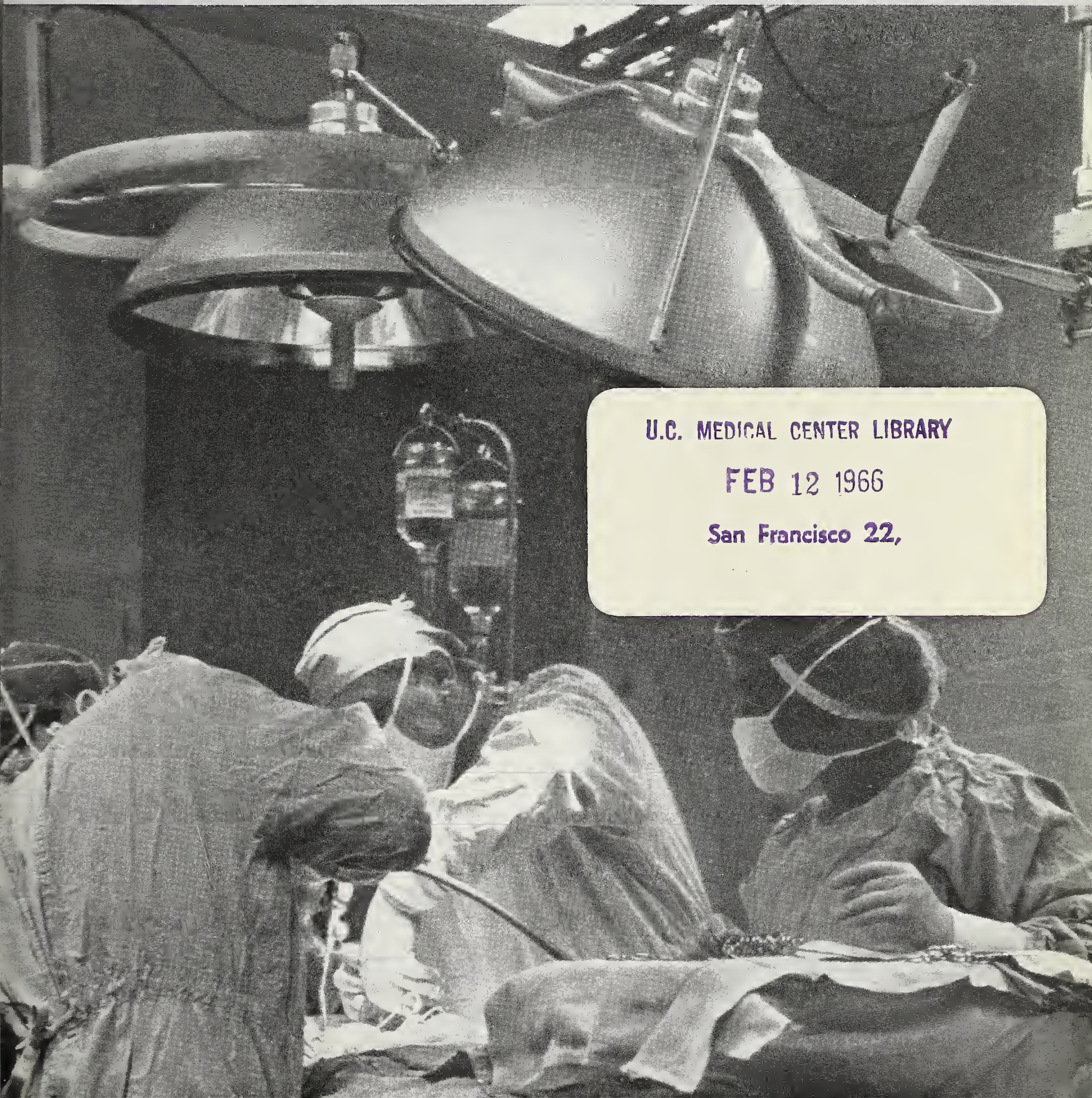
MSMS President Leader participated in rechartering ceremonies recently for the Ingham and Jackson county medical societies, as part of the follow-up after the MSMS Centennial Session. In photo, Lewis L. Stewart, M.D., Jackson president, receives new charter from Doctor Leader.

IN THIS ISSUE: SCIENTIFIC PAPERS ABOUT SURGERY OF PULMONARY EMBOLISM, PLASMAPHERESIS, PSYCHOLOGY AND RELIGION, RUPTURE OF SPLEEN IN LEUKEMIA AND LYMPHOMA □ ALSO, NEWS ABOUT MSMS JUDICIAL COMMISSION, MATERNAL WELFARE CONFERENCE, MEDI-LABELS, AND CHAMBER TASK FORCE RESULT

FEBRUARY, 1966—PUBLISHED MONTHLY

MICHIGAN MEDICINE

MICHIGAN STATE MEDICAL SOCIETY



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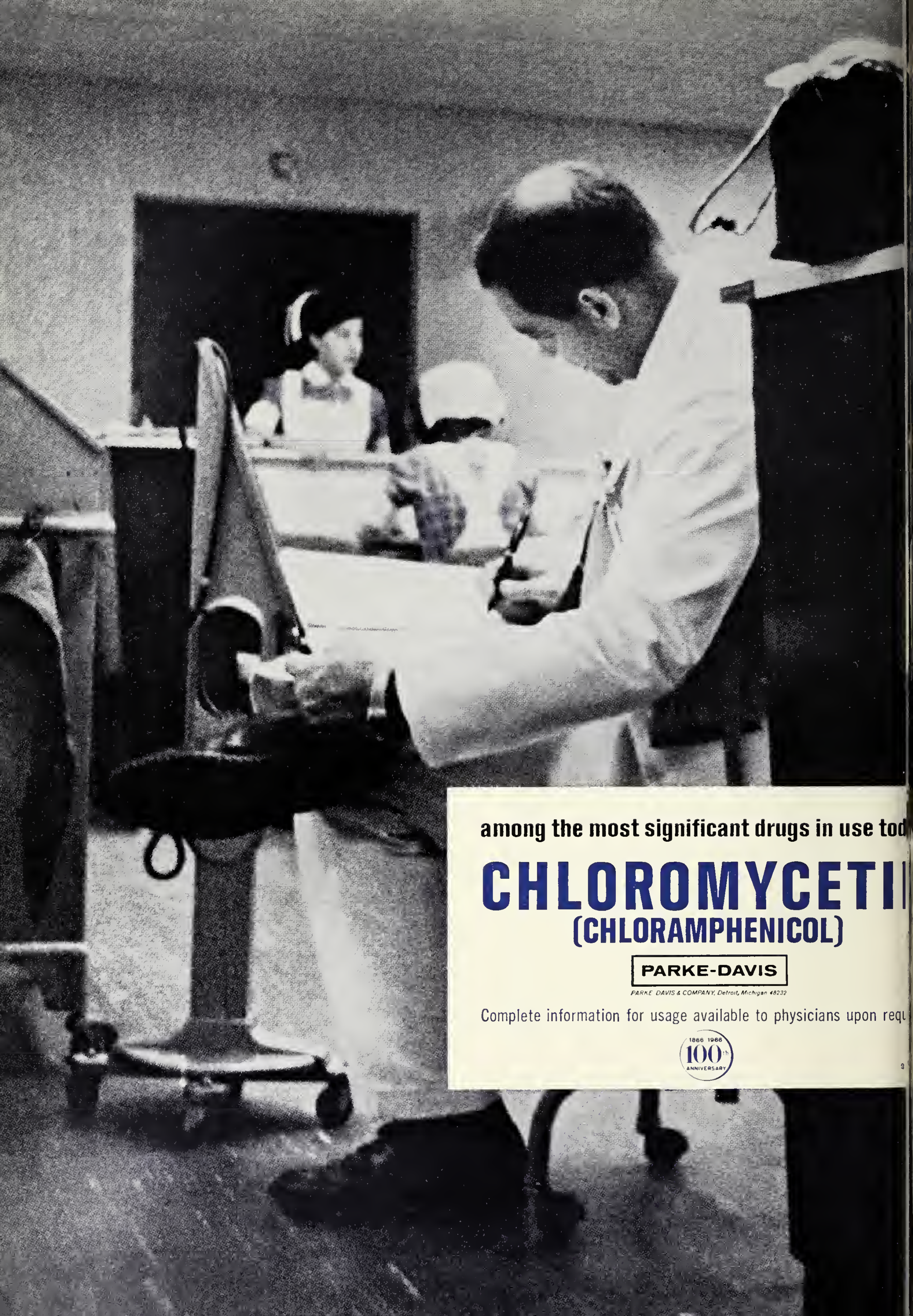

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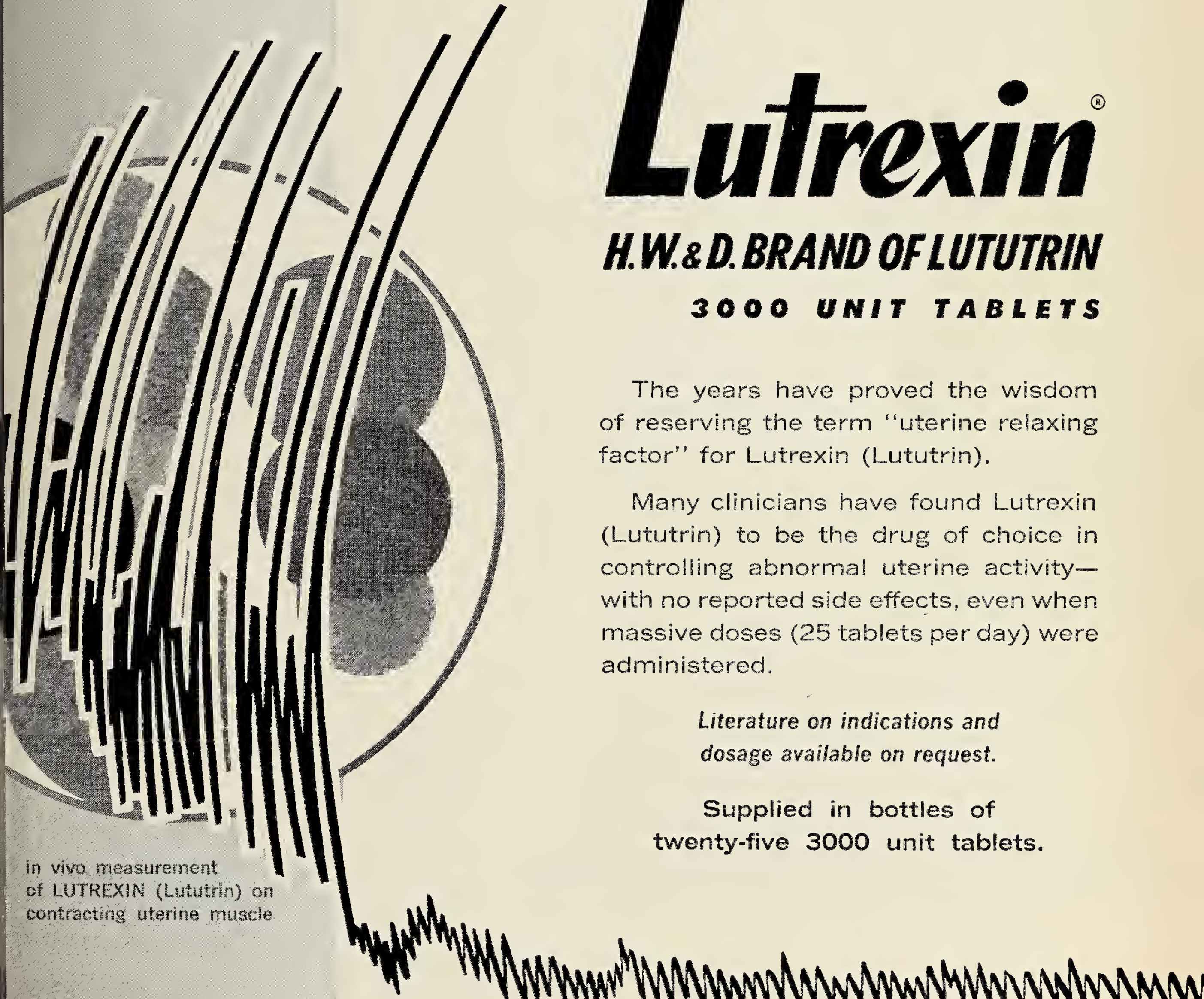

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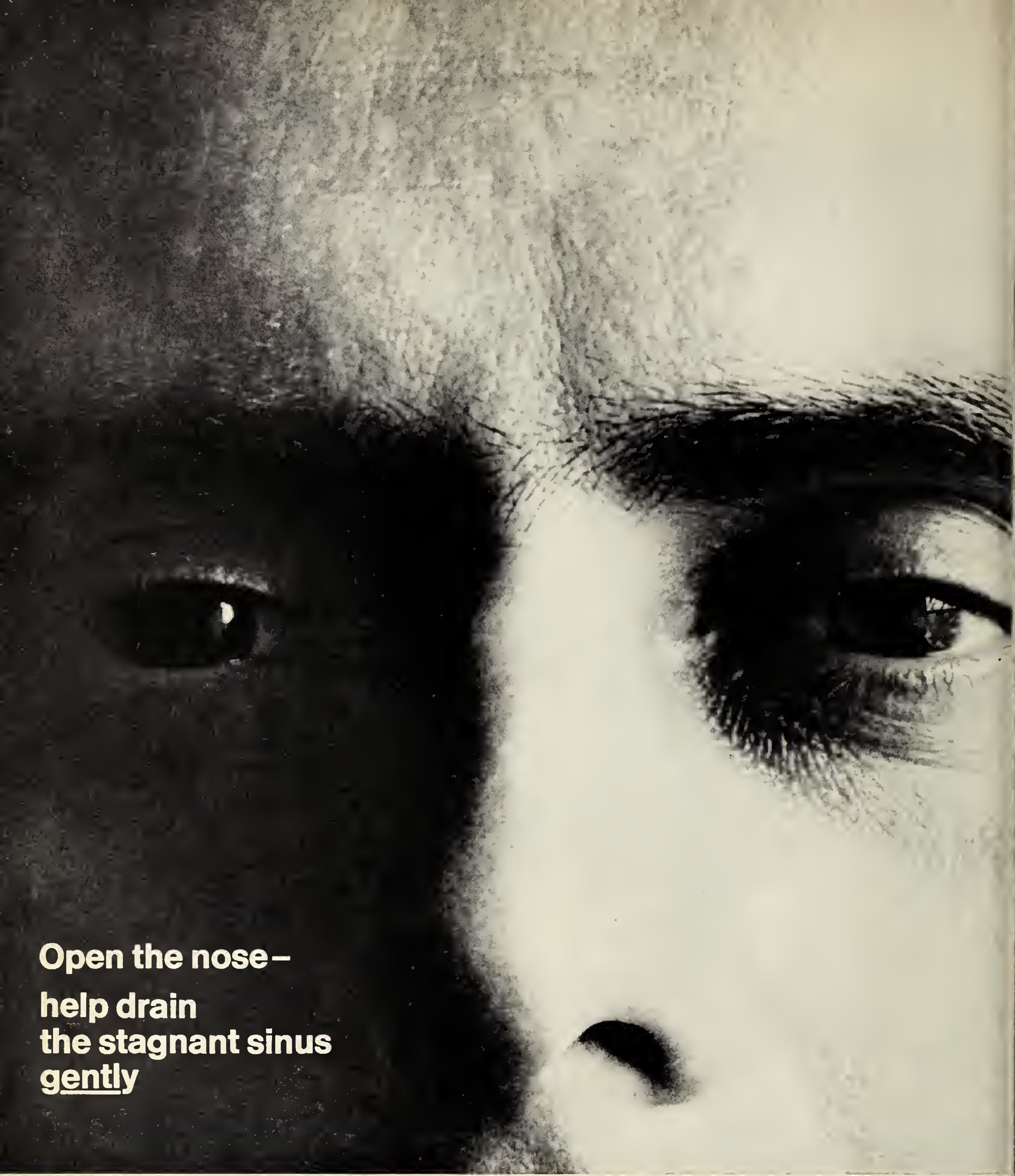
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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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PUBLISHED MONTHLY BY
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MICHIGAN MEDICINE

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Published monthly, except two extra issues to be published in October and December, by the Michigan State Medical Society s its official journal at 2642 University Ave., Saint Paul, Minn. 55114. Second class postage paid at Saint Paul, Minnesota. 'early subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, 2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, ex-anges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East ansing, Michigan 48824. © 1966 Michigan State Medical Society.

THE FORUM QUESTION THIS MONTH:

Should internships be abolished? Please support your "yes" or "no" answer.

HOMER A. HOWES, M.D., Detroit

FRED C. BRACE, M.D., Grand Rapids

W. J. ZIMMERMAN, M.D., Birmingham

D. BONTA HISCOE, M.D., Lansing

WALTER J. ZIMMERMAN, M.D.

Birmingham

Should internships be abolished? Yes! The internship has become an anachronism.

Years ago the rotating internship served a vital purpose in facilitating the transition from the academic medical school experience to the practical requirements of family practice.

But as medical training is presently organized, the graduate heading for a limited specialty needs a longer period of intensive training in his chosen field, and can ill afford the relative non-productivity of a year spent in rotating internship.

The young doctor who elects personal physicianship as his work (under whatever professional label) also needs more postdoctoral training time in a broad program whose organization and emphasis is quite different from the traditional but outmoded internship.

HOMER A. HOWES, M.D.

Detroit

In regard to the question "Should internships be abolished" my answer is:

No. The reason for this answer is based on my own experience as a rotating intern in the University Hospital in Ann Arbor. When I graduated from Medical School I knew I wanted to specialize in internal medicine. Nevertheless, the year I spent as an intern in full-time direct participation in the care of patients in the various other services was most rewarding and has proven to be one of my best training years. Looking back on this year, I believe that the associations I had with the preceptors on the various services have proven to be one of the greatest benefits derived.

At the present time there are not enough interns to fill the internships available. Because a hospital does not obtain its full quota of interns at any one time does not, in my opinion, justify any penalty with regard to accreditation. Likewise, no intern should be denied a position in a qualified hospital which can make suitable arrangements for providing this valuable year of training.

What Are Your Views?

Your opinions are invited for this new Forum feature in MICHIGAN MEDICINE. The question for the April issue will be "Do you believe that hospital planning by law would become a brake or an incentive for innovation toward better quality and economy?" (Explain your opinion, please.)

Write down your suggestions in a letter and mail before February 25th to Michigan Medicine, 120 West Saginaw Street, East Lansing.

B. M. Harris, M.D.
Chairman, Publication Committee

FRED C. BRACE, M.D.

Grand Rapids

Definitely no, internships should not be abolished.

An internship is the step in a medical education in which the young doctor assumes the *responsibility* of applying his theories to reality. It is to both his and the patient's advantage that he does so under supervision.

Without internship and residency programs, many of the advances in medical science would not function

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From a practical view, the patient in general derives more value from the part of his dollar that goes to pay the cost of an intern-residency program in a well-supervised, accredited hospital with a good education program, than he derives from any other part of that dollar.

R. W. EMERICK, M.D.

Fremont

No, internships should not be abolished. This year provides a time for correlation and reinforcement of didactic training. It also enables the graduate to perform, under supervision, various procedures which were not available to him as an undergraduate.

By working with staff physicians it provides a valuable insight into the management and handling of individual patients, thus giving more practice and understanding in the art of medicine.

All of the above factors help produce a better-rounded, better-trained and more competent physician for either entrance into general practice or for further post-graduate specialty training.

D. BONTA HISCOE, M.D.

Lansing

Certainly medical education should not stop with graduation from medical school. Next comes the *raison d'etre,* the practice of medicine. This takes observation as well as experience on the firing line. The new M.D.'s now need to learn to conceive the patient as a whole, and to apply the full spectrum of medical knowledge (all the specialties and ancillar services available) to this particular patient. The initial application of academic knowledge and the firs assumption of responsibility should come while supervision and assistance are still available.

Today's internship does not satisfactorily fulfil these needs. In large teaching institutions the position is an anachronism. In the smaller or communit hospital, exploitation and erratic performance hav made these programs suspect.

The law of supply and demand interferes witl proper control or discipline in many situations especially those where it is most needed. Politics competition for good residencies, make men take internships that distort rather than supplement thei education.

The whole "job description" needs to be redone The emphasis should be on education of the intern not on provision of service to the hospital. Wouldn' it be better to concentrate these positions in medium sized community hospitals (the front line of medicine which are affiliated with medical schools. The students' final degree should not be granted until satisfactory completion of this experience.

One could reduce the premedical four years t three if it were felt that incorporation of the internship over-extended the school program.

GERALD A. DRAKE, M.D.

Petoskey

IN MY OPINION, internships should not b abolished. If it is necessary to reduce the numbe of years involved in a medical education, it woul appear better to do this during the pre-medical year or possibly during the basic science years.

Any physician, regardless of how specialized h prefers to be, should have the type of supervised practical, clinical training, which can only com through a good internship.

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Iealthmobile Visits Eastern Counties

Nine different county medical societies are sponsorig the appearance of the MSMS Healthmobile in ieir communities during the first 10 weeks of 1966.

Following is the schedule as the health-museumn-wheels rolls in the eastern part of the state:

In Washtenaw County, Jan. 14-21
In Lenawee County, Jan. 24-28
In Wayne County, Jan. 28-Feb. 4
In Macomb County, Feb. 4-11
In St. Clair County, Feb. 11-18
In Sanilac County, Feb. 18-25
In Midland County, Feb. 25-Mar. 4
In Saginaw County, March 4-11
In Bay County, March 11-21.

The appearance of the Healthmobile is officially oonsored by the county medical society with the ounty auxiliary responsible for manning the displays.

Wives, working in shifts and looking sharp in white ickets, help answer questions and discuss career oportunities with the parents, children, teachers and ll others.

MSMS officials also are quick to commend the loal newspapers, radio and television stations, schools, ierchants and others for their assistance.

The Healthmobile started at Lansing with the Ingam auxiliary assisting and then appeared under the oonsorship of the county medical societies and auxiaries at Flint, Pontiac, Jackson, Battle Creek, Coldater and Hastings before the close of 1965.

Dedicated at the MSMS Centennial Session, the Iealthmobile describes the advances in medical pracce in Michigan during the past 100 years.

See also page 86.

ISMS Helps Sponsor Family Planning Series

MSMS members served as resource persons at the even regional conferences held during January on amily planning.

MSMS joined eight other health agencies, associaons and institutions in the series of programs.

The workshops were held to acquaint local health nd welfare directors, case work supervisors and thers with the details of the two bills passed by he Michigan legislature on family planning.

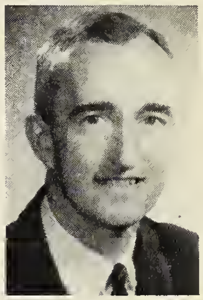
One of the regional meetings was held at the Vayne County Medical Society building.

MSMS, Others Join For Conference on Radiation Treatment

An Oak Ridge medical authority will be the featured speaker at the "Conference on Diagnosis and Treatment of Radiation Accidents," February 10, at the Rackham Building, Ann Arbor.

Gould A. Andrews, M.D., Chairman of the Medical Division of the Oak Ridge, Tenn., Institute of Nuclear Studies, will discuss the conference theme in the morning.

Gould A.
Andrews, M.D.



William H.
Beierwaltes, M.D.

The program will begin at 9 a.m., with introductory remarks by Wm. H. Beierwaltes, M.D., Ann Arbor, professor of nuclear medicine.

The subjects will cover such material as "The Radiation Accident Comes to Your Hospital Today," "Biological Effects of Radiation." "Your Hospital Emergency Plan," and "Decontamination and Waste Disposal."

The session will close at 5 p.m., with the final talk about "Your Radiation Accident Center for Your Hospital, County Medical Society and State."

All interested Michigan physicans are invited to participate in the conference, which will have no registration fee.

Joining to present the one-day program are the Michigan State Medical Society, University of Michigan Department of Postgraduate Medicine, the Michigan Department of Public Health and the Michigan Hospital Association.

WHAT THEY SAY ABOUT HEALTHMOBILE:

Observations and comments by Michigan residents as they go through the MSMS Healthmobile are recorded by the Auxiliary members who are "manning" the health museum-on-wheels.

Following are some of the remarks:

"One man wanted to see the heart-lung machine. He knew much more about the heart exhibit than I did as he had had heart surgery." (Comment from Coldwater)

"A teacher thought all high school science classes would get more out of a visit to the Healthmobile than just reading the textbook." (Comment from Jackson)

"A young man from one of the law firms was among the morning visitors and commented very favorably on the displays and the fine public relations of having the Healthmobile here." (Comment from Battle Creek)

"Most of the students from the Pontiac Practical Nurse Center (established under manpower act) went through the exhibit." (Comment from Pontiac)

"One girl with a cleft palate was especially anxious to have her mother come and see the dental display." (Comment from Coldwater)

"A graduate nurse, now working for a master's degree in public health at U-M, thought the displays were exceptional." (Comment from Jackson)

"Several pre-med students said this was the best display they had ever seen about medical accomplishments." (Comment from Pontiac)

"The older visitors seem most talkative and often tell about their illnesses." (Comment from Battle Creek)

"Pharmacists and dentists who went through thought the exhibits were very good and gave much-needed publicity as to what strides are being made in the medical profession, especially by doctors themselves." (Comment from Pontiac)

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Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

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Abstract of Council Actions

Meeting of December 15, 1965

MICHIGAN DELEGATION TO THE AMERICAN MEDICAL ASSOCIATION

The Council received a detailed report from the Chairman of the Michigan Delegation, William A. Hyland, M.D., following the AMA House of Delegates meeting in Philadelphia. The Council thanked the Delegates for their fine work and referred the report to the Editor of Michigan Medicine for possible publication as information to all MSMS members.

REGIONAL MEETINGS ON FAMILY PLANNING

The Council authorized the appointment, through county medical societies, of representatives to seven regional meetings on family planning. MSMS has participated in planning recommendations. This was referred to the Chairman of the Maternal Health Committee for implementation.

REPORT OF MICHIGAN MEDICAL SERVICE

The report of the MMS President covered the subjects of new auto contract benefits, Medicare, and information going to all physicians regarding Michigan Bell and Kresge accounts.

APPOINTMENTS TO COMMITTEE ON GOVERNMENTAL MEDICAL CARE PLANS

The Council accepted nominations for appointment to this Committee made by President Luther R. Leader, M.D. When acceptances have been received, the membership of the Committee will be announced.

RESIGNATION OF MICHIGAN MEDICINE SCIENTIFIC EDITOR C. J. TUPPER, M.D.

The Council honored Doctor Tupper for his excellent work as Scientific Editor for the past two years and presented him with a suitable memento of The Council's appreciation.

CONFERENCE ON MEDICAL WRITING

The Council advanced plans for a 1966 Conference on Medical Writing, tentatively schedued for May 26 in East Lansing, to be co-sponsored by the Michigan Press Association, Michigan Tuberculosis and Respiratory Disease Association, the MSU School of Journalism and the MSU School of Human Medicine.

DIABETES DETECTION PROGRAM

The Council approved and authorized continuation of the activities of the MSMS Diabetes Committee and of MSMS participation in the Diabetes Detection Program for 1966.

TEACHING GUIDE ON ALCOHOLISM

The Council authorized the MSMS Committee an Alcoholism and Drug Addiction to participate with the Michigan Health Council and the Michigan Education Department of Public Instruction in the development of a possible teaching guide on alcoholism, financed by the State Board of Alcoholism.

ATOMIC MEDICINE REFRESHER COURSE

The Council authorized the Disaster Medical Care Committee to continue its plans for co-sponsoring a Nuclear Medicine Conference at the University of Michigan with refresher courses to follow throughout the state.

POLICY REGARDING HOSPITAL FRANCHISING AND HOSPITAL LICENSING

The following policy regarding hospital franchising was adopted:

(a) The Council does not approve of unlimited governmental franchising of hospital-related facilities.

(b) The Michigan State Medical Society will continue to review with interest any well-thought-out proposal for directing the location of hospitals and related facilities in areas where they can provide needed care with reasonable economy.

(c) Proper professional participation is important and mandatory in all such planning, especially from the Michigan State Medical Society.

The Council also adopted the position that hospital licensing and hospital franchising should be considered separately and through separate pieces of legislation.

The Council also reaffirmed MSMS policy on hospital licensing with the addition of a phrase stating that licensing activities must be under the direction of qualified medical personnel.

MATTERS REFERRED TO THE COUNCIL BY THE 1965 HOUSE OF DELEGATES

Resolution 4 re hiring of the handicapped was referred to the Legal Affairs Committee for implementation.

Substitute Resolution for Resolutions 5 and 16 re support of voluntary approach to area-wide hospital planning was referred to MSMS representatives to the Hospital Research and Educational Reserve of Michigan and the Health Facilities Planning Council and communicated to component medical societies.

Resolution 6 reaffirming MSMS principles regarding medicine's relationship with government was referred to the new Committee on Governmental Medical Care Programs for implementation.

(Continued on Page 90)

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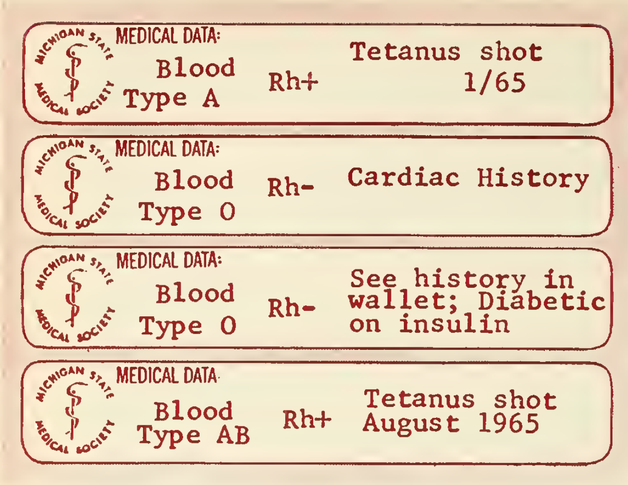
Harbor Springs, Michigan
Harbor Springs 1521



MEDICAL DATA:
Blood Type A
Rh+
Tetanus shot 1/65

MEDICAL DATA:
Blood Type O
Rh-
Cardiac History

MEDICAL DATA:
Blood Type O
Rh-
See history in wallet; Diabetic on insulin

MEDICAL DATA
Blood Type AB
Rh+
Tetanus shot August 1965

WRITE MSMS FOR MORE "MEDI-LABELS"

More of the new "medi-labels" are available from MSMS for interested physicians who want to participate in this new MSMS public-service project.

Developed by MSMS and approved by the Secretary of State, the labels are to be attached to the new Michigan drivers licenses. Space is provided to indicate such information as blood type, tetanus immunization dates, allergies, contact lenses, etc.

The project recently was explained by C. Allen Payne, M.D., MSMS President-Elect, over WZZM-TV in Grand Rapids, with the assistance of M. A. Riley of the MSMS executive staff.

Patients are learning more about this project from posters on exhibit on drivers licensing departments and through the MSMS Healthmobile.

For an extra supply, send an order to Stickers, MSMS, 120 West Saginaw, East Lansing.

MEDISCENE

Feb. 16—Woman's Auxiliary to Michigan State Medical Society Spring Conference, Whittier Hotel, Detroit.

Feb. 25-26—Michigan Heart Association—Annual Heart Day, Sheraton Cadillac, Detroit.

Feb. 25-26—Michigan State Medical Society Officers' Conference, Wayne County Medical Society Building, Detroit.

March 9-10—20th Annual Postgraduate Clinic, Michigan and Wayne County Academies of General Practice, Sheraton-Cadillac Hotel, Detroit.

March 24-25—5th Annual Michigan Conference on Maternal and Perinatal Welfare, Durant-Pick Hotel, Flint.

April 4—45th Annual Beaumont Lecture by Walter Seegers, M.D., at Wayne County Medical Society Building.

April 6—Genesee County Medical Society Cancer Day, Hurley Hospital, Flint.

April 24—Michigan State Medical Assistants Society—9th Annual Educational Seminar, Empire House Motel, Bay City.

May 2-7—Western Michigan Health Fair, Muskegon.

May 11-13—Michigan Public Health Association Annual Meeting, Pick-Fort Shelby Hotel, Detroit.

May 14-15—Michigan Association of the Professions Congress, Pontchartrain Hotel, Detroit.

May 15-21—Michigan Week.

May 26—Conference on Medical Writing, Kellogg Center, East Lansing.

July 16-17—Upper Peninsula Seminar.

COUNCIL ACTIONS/Continued

Substitute Resolution 20 re joint committee to study training for medical assistants was referred to the Education Liaison Committee.

Resolution 25 re feasibility of uniformity in fee schedules was referred to the Committee on Uniform Fee Schedule for Governmental Welfare Agencies.

Resolution 29 re change of MSMS annual meeting date was referred to a committee of The Council for study and report.

Resolution 31 re preparation of RVS for professional pathology services was referred to the Relative Value Study Committee.

Resolution 32 re modernization of Michigan medical practice laws was referred to the Legal Affairs Committee.

Resolution 37 re laboratory medicine was referred to the Legal Affairs Committee.

Resolution 39 re preparation of RVS to cover professional services for diagnostic radiology was referred to the Relative Value Study Committee.

Resolution 41 re statute for implied consent provision in granting motor vehicle drivers licenses was referred to the Legal Affairs Committee.

Resolution 46 re automobile safety design research committee. The Council Chairman was authorized to appoint a committee to meet with medical directors in the automotive industry to explore possible approaches to the implementation of this resolution.

Resolution 50 re committee to evaluate and set up preceptorship in family practice was referred to the Education Liaison Committee for implementation.

2½-3 times more potent than papaverine with a longer duration of action

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SPACOLIN™

(Alverine citrate)

is a potent smooth muscle antispasmodic particularly effective in relieving spastic colon* and spasm of the biliary tract.

*"The diagnosis is based upon a history of catharsis or enema habit, dietary indiscretion or emotional strain, generalized or lower abdominal distress of the type described, abnormality of the bowel movement and tenderness along the course of the colon." *Cecil and Loeb, A Textbook of Medicine, Tenth Edition*

SPACOLIN™ *(Alverine citrate)*

- A specific musculotropic counter-spasmodic.
- NOT an anticholinergic, therefore, has no atropine-like side effects.
- In man, its spasmolytic effect is two and one/half to three times stronger than papaverine with a longer duration of action.
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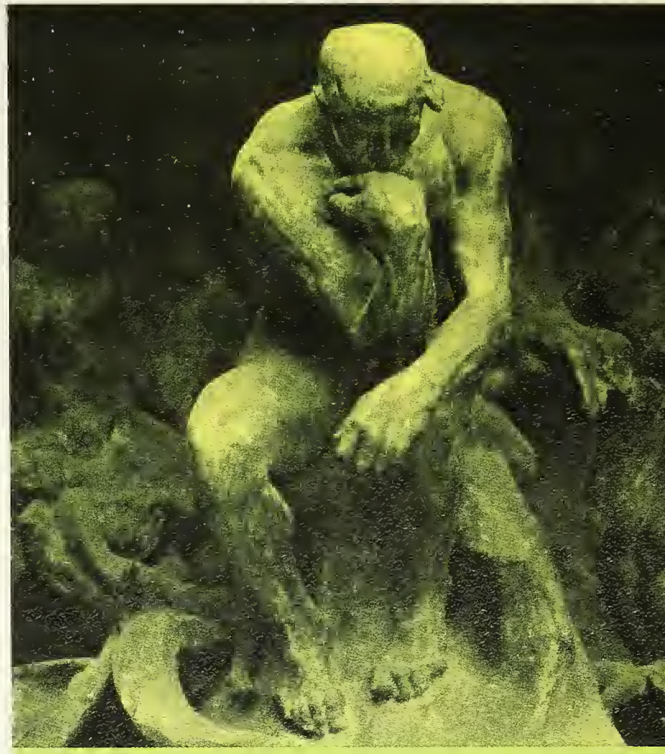
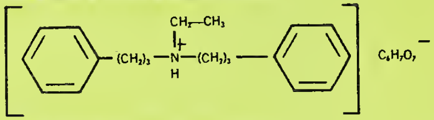
- Mild local anesthetic effect and decreases gastric acidity.

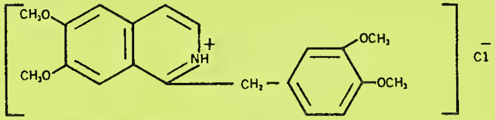


The chemical structures of Spacolin, Papaverine and Atropine are as follows:

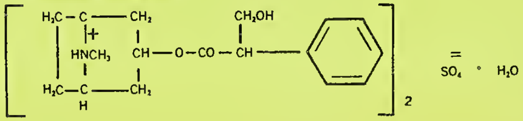
Spacolin (Alverine citrate)



Papaverine Hydrochloride



Atropine Sulfate



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NON-NARCOTIC

For fast relief of spasm

PRODUCT INFORMATION

Each tablet contains: Alverine citrate (Bis-gamma-phenylpropylethylamine citrate) .... 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in **spastic colon,** spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer†, cardiospasm, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations.

†Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, cardiospasm or pylorospasm, administer tablets 1/2 hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort.

PRECAUTION: Caution is recommended when using in hypotensive patients.

SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

SUPPLIED: Bottles of 100 and 500 — 120 mg. tablets.

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orton B. Cash, M.D., St. Mary's Hospital, Livonia, Michigan

ntonio Chiasson, M.D., 4056 Nob Hill Dr., Muskegon, Michigan *(Anesthesiology)*

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eil Garrett, M.D., 17000 W. Eight Mile Rd., Southfield, Michigan *(Urology)*

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dney Joseph, M.D., 1706 Traver Rd., Ann Arbor, Michigan *(Psychiatry)*

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Fredy G. P. Valvekens, M.D., 22146 Ford Rd., Dearborn, Michigan

Rady I. Villaflor, M.D., Children's Hospital, Detroit 2, Michigan *(Anesthesiology)*

Robert B. Wilkins, M.D., Detroit General Hospital, Detroit, Michigan

Helmut Wimmer, M.D., Detroit General Hospital, Detroit 26, Michigan

Russell T. Woodburne, Ph.D., 2023 Devonshire Rd., Ann Arbor, Michigan *(Anatomy)*

Edward L. Yaple, M.D., 403 Bronson Medical Center, Kalamazoo, Michigan

Those Going Abroad Need "Approved Stamp"

The following information about foreign travel is provided to MICHIGAN MEDICINE by George H. Agate, M.D., Director, Division of Epidemiology, Michigan Department of Health:

The Division of Foreign Quarantine of the USPHS has been informed that a large number of persons traveling abroad from the United States fail to have their International Certificates of Vaccination against Smallpox and Cholera properly completed and validated before departure.

In order to be valid, all such certificates for smallpox and cholera vaccination require the "Approved Stamp" of the health officer of the area in which the vaccination has been performed as well as the signature of the physician who did the vaccination. Failure to have the "Approved Stamp" applied may subject the traveler to surveillance or detention according to the requirements of quarantine authorities at the point of arrival abroad where such certificates are required.

In areas of Michigan where there is no local health officer, certificates may be sent or taken to the Michigan Department of Health, Division of Epidemiology, 3500 N. Logan Street, Lansing, Michigan 48914.

no significant weight gain

No statistically significant weight gain has been recorded in patients taking Provest for as long as 12 months. To avoid this undesirable side reaction while providing effective oral control of conception, you can put your patient on Provest. She'll be pleased.

Provest contains medroxyprogesterone acetate with ethinyl estradiol. Both of its components are close chemical approximations of the endogenous hormones involved in ovulation. Provest appears to be free of androgen-like effects; it has produced no hirsutism or voice change, and virtually no acne, in reports to date. Edema has occurred rarely. There have been no reports of liver dysfunction or jaundice, nor of associated chloasma or photosensitivity. The use of Provest has not been attended by any significant change in blood-coagulation pattern or the occurrence of drug-induced depression.

Provest can control conception only when the dosage schedule is faithfully adhered to. To make it easier for your patient to remember, each cycle-course of 20 tablets is supplied in the convenient "forget-me-not" Provest Daypak.*

For a complimentary supply, please write to Dept. 80,
The Upjohn Company, Kalamazoo, Michigan.

Contraindications: It is suggested that Provest not be used in patients with a history of genital or breast malignancy, thromboembolic disease, or hepatocellular or renal disease unless the advantages of this type of therapy outweigh the possible disadvantages. Precautions: Alert patients to possibility of amenorrheic cycle and instruct them to resume Provest tablets on the 7th day following their previous 20-day course, even though the menstrual flow failed to appear. Use drug with caution in patients with cardiac disease, epilepsy, migraine, or asthma. Since fibroids may increase in size with Provest use, watch patients with fibroids. Endometria submitted from patients taking Provest should be suitably labeled for the pathologist making the examination. Use drug carefully in patients with endocrine or metabolic diseases, such as diabetes, since it has not been evaluated in patients with all types of such disorders. Side Effects: Intermenstrual bleeding or spotting may occur, especially in the first two to three cycles of therapy and usually between the 15th to 20th days of medication. Suggested management: (1) spotting—no change in therapy; (2) menses-like bleeding (at mid-cycle or after)—increase to two tablets daily until bleeding recedes or consider this bleeding as a menstrual period, discontinue medication to allow withdrawal bleeding to be completed, and reinstitute therapy on the 5th day of the new cycle. Organic disease should be ruled out if persistent irregular intermenstrual bleeding occurs. Most side effects are those also found in early pregnancy: nausea and/or vomiting, breast tenderness, headache, fatigue, increased or decreased libido, or, very rarely, hair loss. These side effects are minimal and tend to disappear with continued treatment. Dosage and Administration: Administer cyclically one tablet daily from day 5 through day 24 of the menstrual cycle. Available: Provest Daypak of 20 tablets, and bottles of 500 tablets.

*TRADEMARK

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she's pleased she's on

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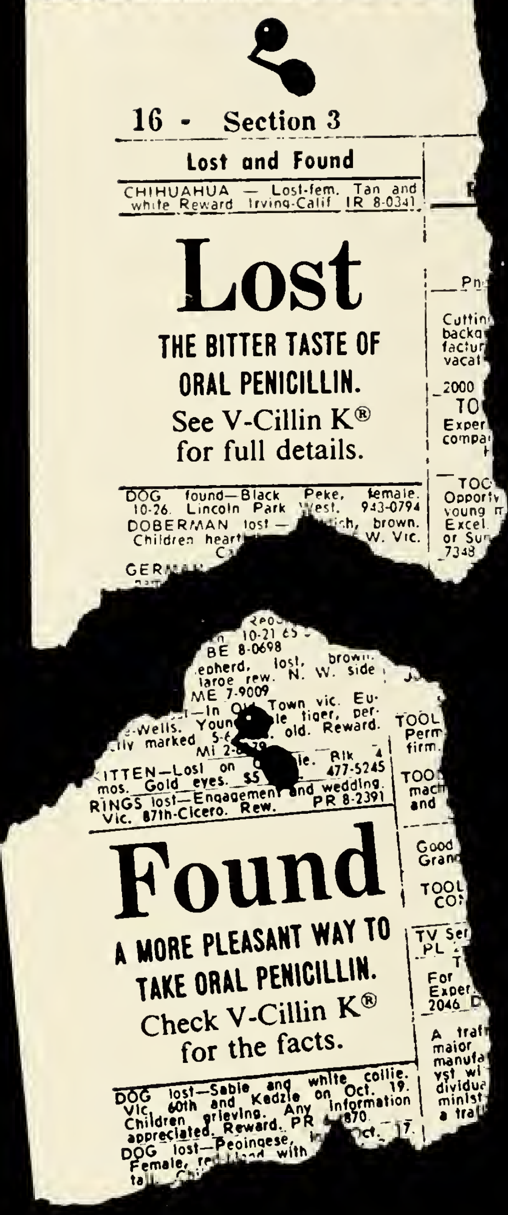

16 - Section 3

Lost and Found

CHIHUAHUA — Lost-fem. Tan and white Reward Irving-Calif IR 8-0341

Lost

THE BITTER TASTE OF ORAL PENICILLIN.
See V-Cillin K®
for full details.

DOG found—Black Peke, female. 10-26. Lincoln Park West. 943-0794

KITTEN—Lost on mos. Gold eyes. $5

RINGS lost—Engagement and wedding. Vic. 87th-Cicero. Rew. PR 8-2391

Found

A MORE PLEASANT WAY TO TAKE ORAL PENICILLIN.
Check V-Cillin K®
for the facts.

DOG lost—Sable and white collie. Vic. 60th and Kedzie on Oct. 19. Children grieving. Any information appreciated. Reward.

Patients won't complain about bitter penicillin taste when you specify V-Cillin K. Here's why: It has a special coating, only one and a half *thousandths* of an inch thick. Because it is designed to dissolve after approximately six seconds, this barrier to bitterness remains on the tablet as it slides past the tongue. When the tablet reaches the stomach, however, the coating has dissolved, and the penicillin is ready for immediate absorption into the bloodstream.
Result? The proved efficacy of potassium penicillin V without the penalty of bitter taste.

Indications: V-Cillin K is an antibiotic useful in the treatment of streptococcus, pneumococcus, and gonococcus infections and infections caused by sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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ORIGINAL
SCIENTIFIC
ARTICLE

The Surgical Treatment Of Massive Pulmonary Embolism

By Paul G. Firnschild, M.D.
Detroit

Massive pulmonary embolus is a catastrophe from which the critically ill patient may be saved with accurate diagnostic procedures and rapid surgical intervention. The rapid institution of cardiopulmonary bypass may determine the difference between success and failure.

As early as 1908, Trendelberg observed that all patients with massive pulmonary embolus did not die immediately but that many lived for hours or days, and he proposed surgical removal of massive pulmonary embolus.[1] His early attempts were unsuccessful, but Kirschner, in 1924, reported the first successful removal of a massive pulmonary embolus.[2] Until the first case using cardiopulmonary bypass was reported, 23 patients were reported to have survived using the Trendelberg procedure.[3]

The use of cardiopulmonary bypass has offered a more hopeful outlook for the patient critically ill with massive pulmonary embolus. In 1961, Sharp performed the first successful removal of a massive pulmonary embolus using cardiopulmonary bypass,[4] Cooley and Beall reported a successful case shortly thereafter.[5] Since then, an increasing number of patients with massive pulmonary embolus have been saved by the use of cardiopulmonary bypass and immediate pulmonary embolectomy.

Case Report

The patient, a 54-year-old white female, had been discharged from another hospital two weeks previously following a uterine dilatation and curettage. During this hospitalization she developed redness, swelling and tenderness of the right thigh which had gradually responded to symptomatic therapy.

She remained well at home until 9:00 a.m. on March 24, 1965, when she suddenly developed left chest pain, dyspnea, cyanosis and became comatose. She was immediately brought to the Emergency Room of the other hospital where she was seen by her family physician. Her blood pressure was 100/60 mm Hg, pulse 140 per minute and respirations 40 per minute. She was extremely cyanotic and respirations were gasping. Serial electrocardiograms revealed ST depression and sinus tachycardia. Serum transaminase was 22 units, lactic dehydrogenase 560 units, urea nitrogen 16.3 mg% hemoglobin 15.5 gm per 100 ml. hematocrit 47%, white blood count 15,150 per cu mm. She was given vasopressors, Digitoxin, Dilauded and nasal O_2.

She gradually regained consciousness and her blood pressure rose to 120/80 mm Hg, but she remained cyanotic and gasping respirations continued. The pulmonic second heart sound was accentuated, jugular veins were distended, and the lung fields were clear. A diagnosis of massive pulmonary embolus was made by the family physician, Doctor Peter Moser of Flat Rock, and she was transferred to Harper Hospital.

Cardiac catheterization was performed at once using a No. 7 cardiac catheter inserted into the median cubital vein and passed to the right ventricle under fluoroscopic control. Thirty milliliters of Renovist were injected using 200 pounds pressure and a series of 12 films exposed at 0.5 second intervals using a Schonder apparatus.

The pulmonary angiogram revealed complete block of the left pulmonary artery and obstruction of the lobar arteries of the right lung. (Figure 1)

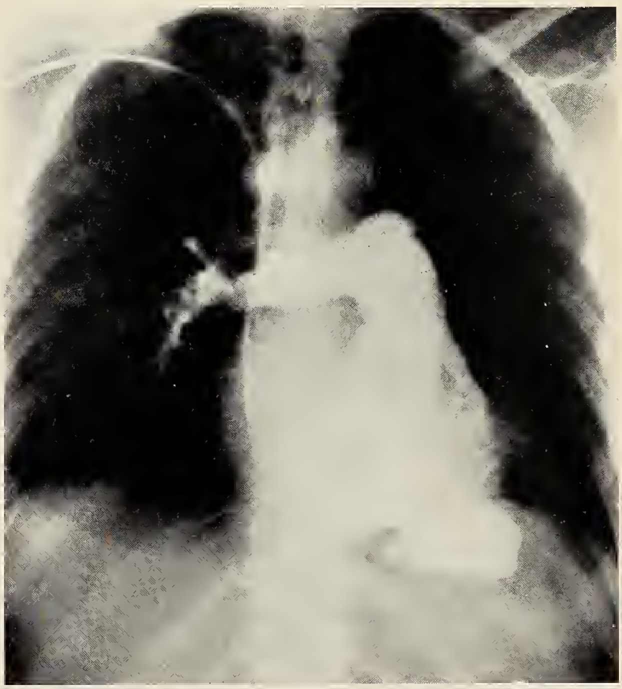

Figure 1. Pulmonary angiogram revealing obstruction of left main pulmonary artery and lobar arteries of right lung.

The patient withstood the procedure well but remained cyanotic and dyspneic with gasping respirations and lasped into unconsciousness periodically. Blood pressure ranged from 100/60 mm Hg to 120/80 mm Hg.

She was taken to the operating room where preparations for cardiopulmonary bypass were being made. The patient was anesthetized with Sodium Pentothal, Fluothane and nitrous oxide. A medium sternotomy was performed at 7:30 p.m., three hours after admission, and 10½ hours after the onset of symptoms. Upon entering the pericardium, the pulmonary artery was found to be markedly distended as were the right ventricle, right atrium and venae cavae. The myocardium was cyanotic.

The patient was placed on cardiopulmonary bypass using a disposable bubble diffusion oxygenator and roller pump. The priming solution was 5 per cent glucose in distilled water. The flow was maintained at 2500 milliliters per minute. The main pulmonary artery was opened longitudinally and a suction tip introduced into both main pulmonary arteries. Large thrombi were removed from each side. (Figure 2) The pleural spaces were entered and manual compression of the lung performed. Using this procedure, with irrigation of the pulmonary arteries, several additional large thrombi were removed. This process was continued until liquid blood appeared upon compression of the lung.

The pulmonary arteriotomy was then closed and cardiopulmonary bypass terminated. Total bypass lasted 25 minutes. Blood pressure was maintained at 90/60 mm Hg. The chest was closed with thoracotomy tubes in each side.

Postoperatively the patient did not respond to verbal or painful stimuli but corneal and pupillary reflexes remained intact. The heart rate was 96 per minute, venous pressure 12 cm of water, and respirations 20 per minute. Lateral nystagmus was noted and her extremities were flaccid. Chest x-ray revealed a diffuse density involving the left lung. A tracheostomy was done and her respirations and color remained satisfactory. Blood pressure gradually rose to 110/70 mm Hg the day after surgery and the left lung field gradually cleared over the next few days. Electrocardiogram revealed only signs associated with status postoperative pericardiotomy. Four days postoperatively she began to respond to tracheal aspirations with facial movements.

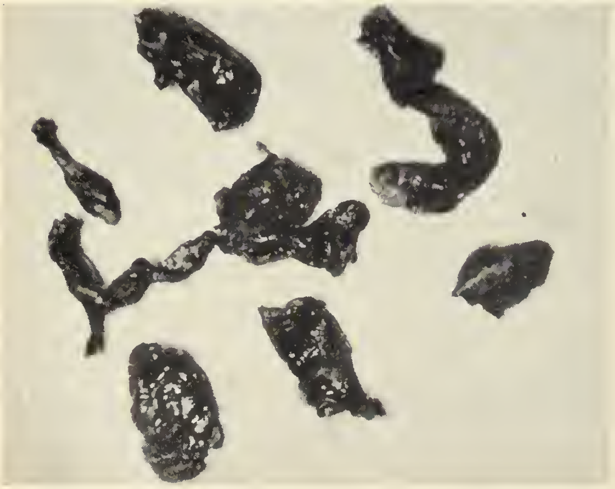

Figure 2. Emboli removed at operation.

Progressive improvement occurred and on the eighth postoperative day she conversed coherently and moved all extremities. To prevent recurrent embolization a serrated edged clip was applied to her inferior vena cavae through a right flank incision. This produced minimal swelling of the lower extremities. She was discharged, one month after admission, having completely recovered all faculties.

Discussion

The diagnosis of massive pulmonary embolus can frequently be suspected from clinical manifestations. However, the physical signs of sudden dyspnea, cyanosis, tachycardia, hypotension, distended neck veins and frequently loss of consciousness are suggestive, but not diagnostic.

When doubt remains, and to eliminate the possibility of error, pulmonary arteriography is feasible and offers a high degree of accuracy. Pulmonary arteriography is potentially the most positive means for diagnosing thromboembolism of the lung. Pulmonary arteriography alone offers sufficient evidence to warrant surgical intervention in the critically ill patient in whom procrastination may be fatal. The embolus can be conclusively demonstrated with safety in a relatively short period of time and may prevent needless operative intervention in a critically ill patient.[6]

Many patients with massive pulmonary embolus succumb within seconds and before medical attention is available. Others live for hours or days following the initial episode and it is this group that is amenable to embolectomy using cardiopulmonary bypass.

From 30 to 50 per cent of patients with massive pulmonary embolus are reported to live long enough for pulmonary embolectomy to be undertaken.[7] Still another group of patients sustain extensive pulmonary embolus without any threat to life and in these pulmonary embolectomy is not indicated although some of these may develop pulmonary difficulty eventually.

Occlusion of at least 60 to 70 per cent of the ascular bed is necessary to produce elevation of ulmonary blood pressure.[8] The systemic blood ressure will usually fall and the right heart chamers dilate with accompanying cardiac failure. lyocardial and cerebral anoxia appear in a short me and are signs of severe and frequently fatal ulmonary embolus. It is then that immediate upport by cardiopulmonary bypass is crucial.

The use of 5 per cent glucose in distilled water as priming solution, with a disposable bubble difusion oxygenator, greatly facilitates immediate ulmonary embolectomy by eliminating the need or large volumes of heparinized blood. Experiiental and clinical application have shown the useulness of this perfusion system.[9]

Summary

Massive pulmonary embolus is a serious threat life from which a significant number of patients urvive long enough for surgical intervention.

The use of diagnostic pulmonary arteriography dds little to the risk and ensures accurate diagosis. The immediate institution of cardiopulmonry bypass may be critical and is facilitated by tilizing a 5 per cent glucose in water priming soluon with a disposable bubble oxygenator. Ligation f the inferior vena cavae to prevent recurrent mbolization is indicated. A successful pulmonary mbolectomy in a 54-year-old woman using the chniques described is reported.

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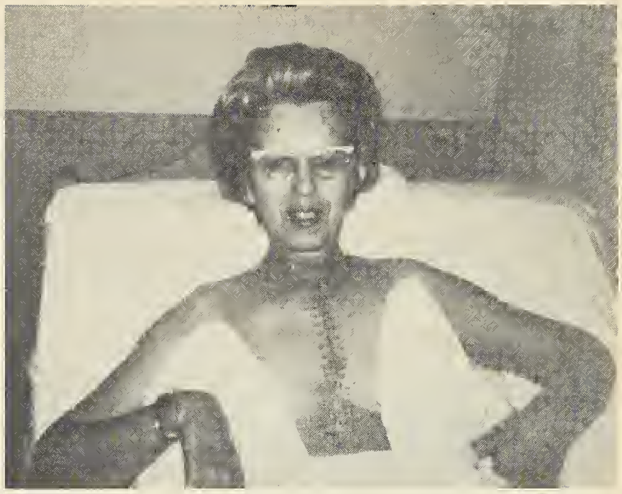

Figure 3. Three weeks post pulmonary embolectomy.

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Paul G. Firnschild, M.D., 1501 David Whitney Building, Detroit 26, Michigan.

Ends Many Years As Radiology Editor

Howard P. Doub, M.D., Detroit, retired recently as editor of Radiology, the official journal of the Radiological Society of North America. He has held this position since 1941, after serving as associate editor for several years.

Dr. Doub served as president of the RSNA in 1938 and the American College of Radiology in 1954. He was recipient of the RSNA gold medal in 1950 and the ACR gold medal in 1962.

A charter member of the Detroit Roentgen Ray and Radium Society, he served as its president in 1928-29. He has also served as president of the Southeastern Michigan Division of the American Cancer Society and of the Michigan Cancer Foundation.

A Simple Splint For the Emergency Room

Maurice E. Castle, M.D.
Pauline Erpelding, R.N.

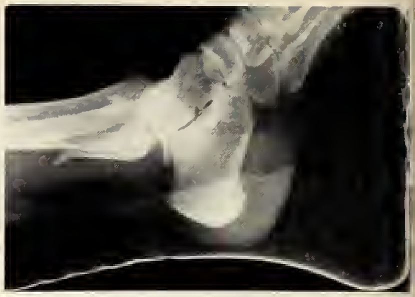

Figure 1. Note how the foot has pulled up, producing pressure on the heel.

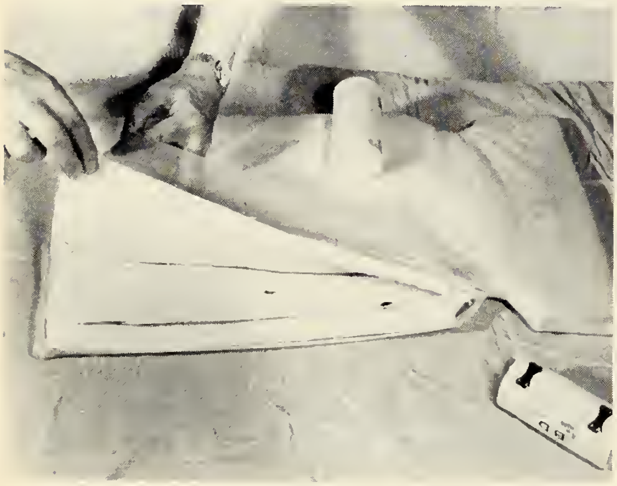

Figure 2

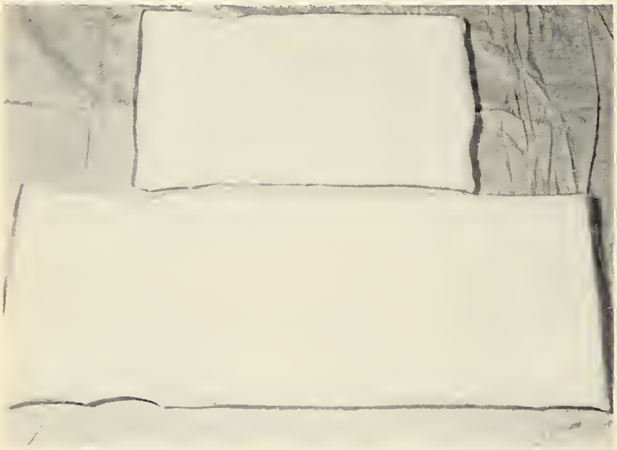

Figure 3

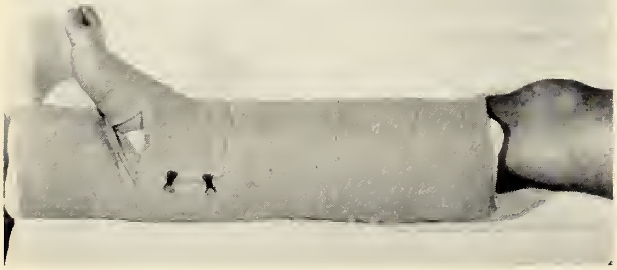

Figure 4

The problem of pressure sores about the heel and ankle in patients left for any length of time in many of the metal splints common to emergency rooms is well known (**Figure 1**).

These sores can occur in spite of what appears to be adequate precautions regarding padding, application, etc.

An effort to reduce or eliminate this bothersome complication led to the design of a wrap around type splint. It has been gratifying to note that there have been no pressure sores since the inauguration of its use. The present splint not only provides adequate immobilization for the emergency room patient, without fear of pressure points, but also provides a compression which tends to reduce the amount of swelling present.

It consists of a piece of sponge rubber, one inch thick, and approximately 12 by 24 inches. The long edge is split on both sides so that a piece of yucca board may be placed as reinforcement. There is an oval area cut out for the foot (**Figures 2 and 3**). The entire splint is then covered by clear plastic and stockinet, with the edges taped in place by adhesive tape. The splint is then simply wrapped around the leg by means of one or more ace bandages, with several turns of the ace bandage around the distal foot (**Figure 4**). If the stockinet becomes soiled, it is easily replaced by the emergency personnel. The sponge rubber has the advantage over such materials as felt, etc., in that it can be washed easily. A second size for the upper third tibial fracture of 12 by 36 inches, has also worked out very satisfactorily.

Summary: A simple wrap around splint that can be made in any emergency room, is hereby reported. This splint has eliminated the bothersome problem of pressure sores in our emergency service. It also has the advantage of adding the compression principle to the prevention of edema.

Maurice E. Castle, M.D., is Assistant Clinical Professor, Orthopedic Surgery, Wayne State University Medical School, and Member of Active Staff, Mt. Carmel Mercy Hospital Department of Surgery, Detroit.

Pauline Erpelding, R.N., is Head Nurse, Emergency Room, Mt. Carmel Hospital, Detroit.

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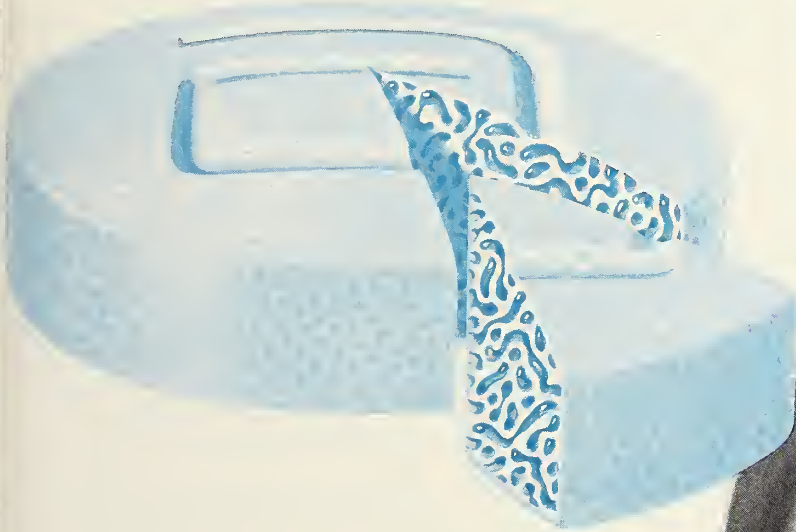

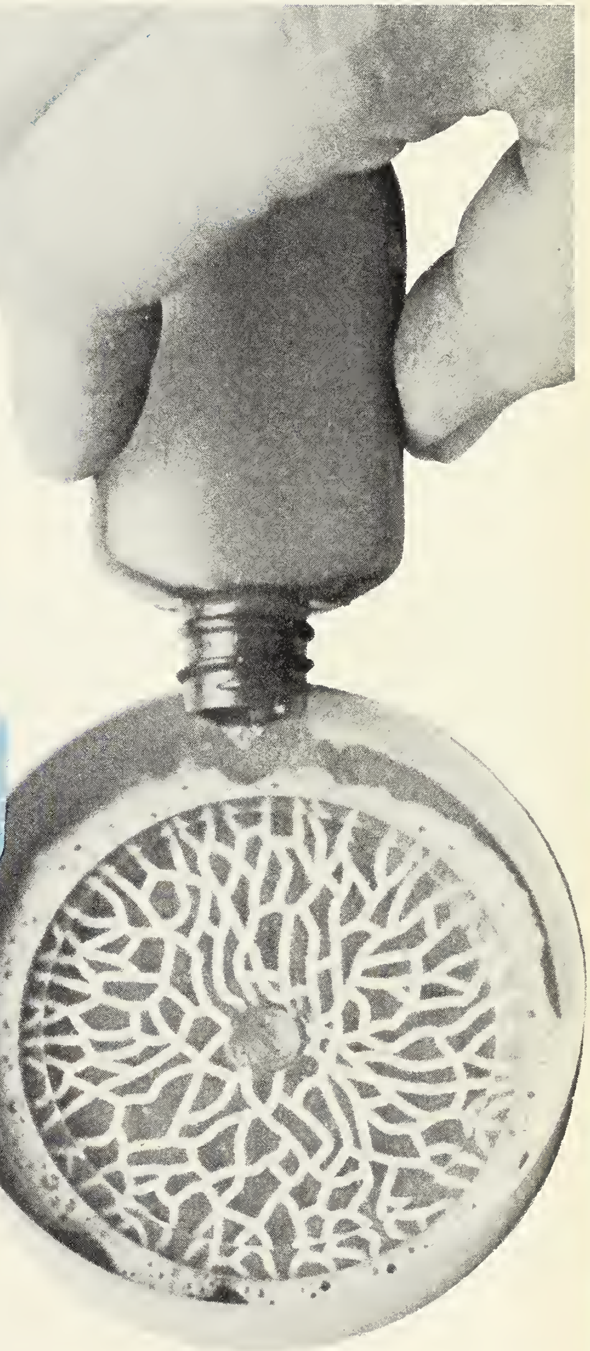

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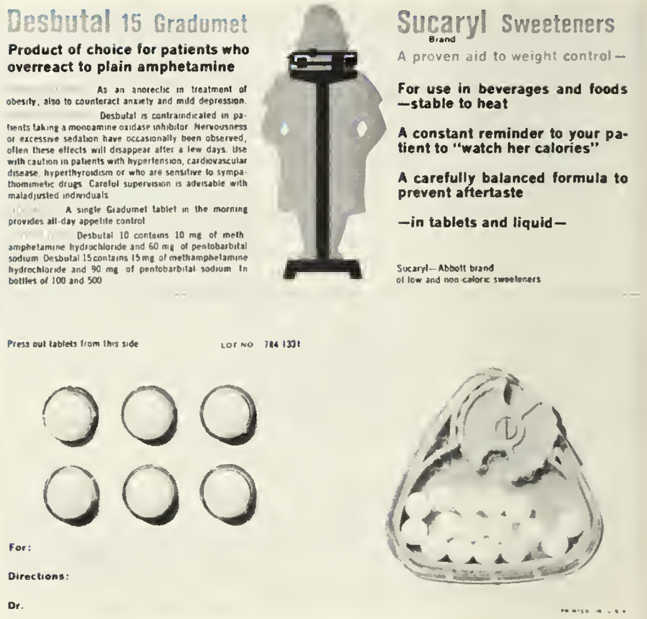

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ORIGINAL
SCIENTIFIC
ARTICLE

Pathologic (So-called Spontaneous) Rupture of Spleen In Leukemia and Lymphoma

3y ROMAN KNOBLICH, M.D.
'LINT, MICH.

Since the first description by Rokitansky[1] in 1861 f two instances of rupture of the spleen in leukenia, only 29 additional cases have been reported.[2-27] Rupture usually occurred in patients in whom the presence of leukemia or lymphoma was not preiously obvious, and frequently rupture was the intial event pointing to the leukemia or the lymphoma. It was, therefore, thought worthwhile to eview the reported cases and to describe five adlitional examples, one occurring in a patient with ymphatic leukemia, one in a patient with myelononocytic leukemia and three occurring in patients vith Hodgkin's disease. The occurrence of pathologic rupture of the spleen in Hodgkin's disease as not been recorded in the medical literature previously.

CASE #1

A 69-year-old white woman was admitted to Wayne County General Hospital complaining of a umor in the abdomen. She stated that during the previous three months she had lost 40 pounds in veight, and had nausea, loss of appetite, and weakiess. During the last three weeks she had noticed listention of the abdomen and had felt a tender nass in the left side of the abdomen.

PAST HISTORY: The patient had had a hysterectomy and appendectomy 20 years previously, inermittant edema of ankles for several years, and hortness of breath on climbing stairs for two days rior to admission, but no dyspnea or orthopnea. She had always been quite susceptible to bruising.

PHYSICAL EXAMINATION revealed a blood pressure of 160/80 mm Hg; respiratory rate of 20 and pulse rate of 110/minute. The level of the left eaf of the diaphragm was 3 cm above that of the right. On cardiac examination, a grade II systolic murmur was heard at the apex and a grade I systolic murmur, in the aortic area. The abdomen was generally distended and an old midline surgical scar was present. A firm tender mass in the left upper quadrant extended to the midline and to a level of 2 cm below a line drawn from the umbilicus to the iliac crest. The edge of the mass was sharp and irregular. Bowel sounds were heard over the right side of the abdomen but not over the left side.

The patient was seen lying quietly on her back, but complained of pain in the left upper portion of the abdomen when she turned from side to side or sat up. Pyelogram obtained after intravenous injection of dye showed evidence of a mass anterior to the left kidney. At the day of her admission, the blood urea nitrogen was 13 mg/100 ml, hemoglobin 7.8 gm/100 ml, hematocrit reading 27; WBC 7,800; polymorphonuclear leukocytes 27 per cent; lymphocytes 69 per cent, some of which were abnormal; monocytes 3 per cent; myelocytes 1 per cent. The serum electrolytes were within normal range and the presumptive heterophil agglutination test was negative. Bleeding and clotting times were within normal range and the prothrombin time was 26 per cent; serum alkaline phosphatase was 3.3 units; and serum proteins were normal.

On the evening prior to the day of her death the patient complained of pain in the left upper quadrant of the abdomen, shortness of breath, and dizziness. She was found to be in impeding collapse, her lips moderately cyanotic, and her skin cold and clammy. The hematocrit reading was 17 and the blood pressure 80/0 mm Hg. Later she lapsed into coma, and oxygen and levarterenol were given without avail. She died rather suddenly, five days after admission.

AUTOPSY FINDINGS: On opening the abdominal cavity, approximately 1,000 ml of dark clotted blood was found, predominantly in the anterior portion of the abdomen, just above the anterior surface of the spleen. The spleen was greatly enlarged, and weighed 3,600 gm. The capsule was slightly thickened, and presented a transverse tear, 12 cm long and 2 cm deep on the anterior surface,

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and another tear 3 cm long on the inferior surface. A large hematoma was adherent to the anterior surface. Two small irregularly round, yellow-gray, firm nodules were present within the soft pasty parenchyma. The lymph nodes, especially the mesenteric and periaortic lymph nodes, were enlarged and on section, gray-white and firm. The bone marrow was red-brown and soft.

On microscopic examination of the spleen, the sinusoids were moderately dilated and filled with large, rather uniform cells which resembled large immature lymphocytes. The cells had abundant pale pink cytoplasm and dark hyperchromatic nuclei; and many of the nuclei had prominent nucleoli. Small mature lymphocytes and some plasma cells were also present. Silver inpregnation showed a relative increase of the reticulin fibers as compared with a section from a normal spleen. In the area of the tear, the splenic tissue was diffusely infiltrated with erythrocytes enmeshed in fibrin.

The bone marrow was hyperplastic, with cells predominantly of the myeloid and erythroid series. Scattered throughout were large cells similar in appearance to those described in the spleen. The fatty component was reduced to approximately 10 per cent of the marrow. The lymph nodes in general showed loss of normal architecture, and contained cells smaller than those present in the spleen. The predominating cells in the lymph nodes had somewhat irregular nuclei which were much larger than the nuclei of mature lymphocytes, and many had prominent nucleoli. The periportal spaces of the liver were heavily infiltrated with large immature lymphocytes. The cerebral dura had patchy infiltration by similar cells.

PATHOLOGIC DIAGNOSIS: Exsanguination from pathologic rupture of spleen in lymphatic leukemia, myocardial hypertrophy, sclerosis of coronary arteries, pleural effusion, focal pyelonephritis and cystitis.

CASE #2

A 64-year-old Negro male was admitted to Wayne County General Hospital complaining of shortness of breath, malaise and bleeding from the gums. His past medical history was unrevealing.

PHYSICAL EXAMINATION showed the patient to be well developed, well nourished and lethargic.

Hematologic examination showed a profound pancytopenia with a platelet count of 25,000. The Hg was 5 gm, RBC 1,430,000/mm,[3] the red cells showed anisocytosis and moderate poikilocytosis; hematocrit reading was 16; MCV 112 cubic u; MCH 35 uu gm; MCHC 32 per cent; WBC 3,900/mm.[3] The differential count showed 92 per cent polymorphonuclear leukocytes of which 72 were filamented and 20 non-filamented, and 8 per cent lymphocytes. Bleeding and clotting time were within normal range.

Lymph nodes removed from the inguinal region showed involvement by Hodgkin's disease. A bone marrow biopsy revealed normocellular bone marrow elements with a decreased number of megakaryocytes. The patient received multiple blood transfusions over a period of one year. During this time the pancytopenia persisted and was relieved by whole blood transfusions and platelet rich plasma.

During the last two months before the patient's death he was treated with Prednisolone and Fluoxymesterone 2 mg/day, in addition to the repeated blood transfusions. An acute hemorrhagic and persistent gingivitis and maxillary sinusitis were treated with Tetracyclines. One month prior to death a bone marrow aspiration showed 84 per cent highly atypical reticulum cells in an otherwise hypocellular bone marrow. The peripheral leukocyte count remained between 1000-2000 and showed a preponderance of highly atypical cells resembling reticulum cells. The patient expired without dramatic event about one year after his first admission.

AUTOPSY FINDINGS: On opening the abdominal cavity approximately 1,000 ml of uncoagulated blood was found. The spleen weighed 610 gm and was of mushy consistency. Adherent to the inferior surface was a piece of omentum. A small tear was noted in the superior surface of the splenic capsule. Clotted blood adhered to the superior surface of the spleen and to the under surface of the diaphragm. The splenic parenchyma was of red-brown color with innumerable small irregular hemorrhagic areas scattered throughout it. The lymph nodes of the neck were enlarged measuring 0.5 to 1.5 cm in diameter. The retroperitoneal and mediastinal lymph nodes were equally prominent. The bone marrow was red-brown. Microscopic examination of the spleen and lymph nodes showed complete obliteration of the normal architecture due to diffuse infiltration of the tissue by reticulum cells. In some areas the picture was consistent with

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Hodgkin's disease. The cells infiltrating kidney, liver, bone marrow and dura were consistent with malignant reticulum cells.

PATHOLOGIC DIAGNOSIS: Exsanguination from pathologic rupture of spleen in Hodgkin's disease. Hodgkin's disease terminating in reticulum cell leukemia; leukemic infiltration of liver, spleen, kidneys, lymph nodes and dura. Aspiration pneumonitis, bilateral; organizing pneumonia, bilateral; mycotic granuloma (Aspergillus or Candida) of lung.

CASE #3

A 62-year-old Negro male admitted to Wayne County General Hospital complaining of swelling of the neck, anorexia, chills and fever for three weeks.

PHYSICAL EXAMINATION showed the lymph nodes generally enlarged. Especially prominent were the lymph nodes in the neck, axilla and groins. Moderate enlargement of the liver and marked enlargement of the spleen were present.

A supraclavicular lymph node was removed and histologically diagnosed as Hodgkin's disease. Bone marrow examination showed the marrow elements present in normal proportions and forms. The hemoglobin was 16 gm; RBC 5,660,000; WBC count 6,300, with 95 per cent polymorphonuclear cells, 77 of which were filamented and 17 non-filamented; 4 per cent lymphocytes and 1 per cent eosinophils; hematocrit reading 52; MCV 92 cubic u; MCH 28 uu g; MCHC 30.5 per cent; platelets 152,800 reticulocytes 1.1 per cent. The sickle cell test was negative; the hemoglobin electrophoresis showed AA hemoglobin; the hemoglobin alkali denaturation and the test for cold agglutinins were negative. The serology was negative. Serum protein, BUN, glucose and electrolytes were within normal limits.

The patient was treated with radiotherapy and nitrogen mustard. One month after admission the patient became hypotensive with a blood pressure reading of 74/52 mm Hg. The hematocrit reading decreased to 26.5 and the abdomen became distended. Paracentesis was performed and 4,250 ml of bloody fluid were removed from the abdomen. The hematocrit readings on the paracentesis fluid was 7.

Shortly thereafter a second paracentesis revealed a hematocrit reading of 34. The patient expired despite blood and fluid replacement.

AUTOPSY FINDINGS: On opening the abdominal cavity 2,000 ml of liquid blood were found. The spleen weighed 970 gm. Areas of rupture of the capsule were noted in the superior and inferior surface of the spleen. On cut, the splenic tissue showed a fine yellow-white granular surface. The lymph nodes throughout the body were enlarged and had a homogeneous gray-white appearance. The largest lymph nodes measured up to 4 cm in diameter. Histologic examination of the spleen and lymph nodes showed a pleomorphic picture with lymphocytes, polymorphonuclear cells and numerous Reed-Sternberg cells. Fibrosis was noted in some areas.

PATHOLOGIC DIAGNOSIS: Exsanguination from pathologic rupture of spleen in Hodgkin's disease. Hodgkin's disease involving lymph nodes, spleen and liver; acute bacterial endocarditis (Staphylococcus aureus and gamma Streptococcus), septic emboli to kidneys, brain and heart.

CASE #4

A 53-year-old white male experienced tingling and numbness of the inner aspect of the left arm. He was treated with Vitamin B-12 with little remission of symptoms and was seen for neurological work-up at which time an old peripheral neuritis of the left arm was found. About six weeks prior to admission to Hurley Hospital he noted extreme tiredness and fatigue, experienced multiple aches and pains in his feet. Five days prior to admission he complained about painful and sore gums, sore throat, pain in his left ear and headache. In the past the patient had had many nosebleeds; however this had not occurred for some weeks prior to admission. Weight loss was not noted by the patient. The family history showed that his brother had died of leukemia.

PHYSICAL EXAMINATION showed a well-developed, well-nourished male. Small ulcerations of the gums were present and hypertrophy of the mucosa covering the gums was noted. The posterior cervical lymph nodes were slightly enlarged. The liver and spleen were thought to be moderately enlarged. Rectal examination showed slight enlargement of the prostatic gland. An otitis externa of the left ear was present. The lungs were slightly hyperresonant. The rest of the physical examination did not reveal any abnormality. During the first four days of the patient's hospital stay his temperature was about 100 degrees F. From then throughout the entire hospital stay the temperature remained normal.

LABORATORY EXAMINATION: Urine examination was unremarkable. The uric acid was 8 mg/100 ml; the chloride, sodium, potassium and CO_2 were within normal limits. The total protein 6.2 g/100 ml. Serum electrophoresis showed 3.86 g/100 ml of albumin, 0.23 A^1 globulin, 0.54 A^2 globulin, 0.65 Beta globulin and 0.92 g/100 ml gamma globulin. The total bilirubin was 0.4 mg, the direct bilirubin 0.2 mg. The hemoglobin was 12 gm/100 ml, the hematocrit 38, WBC 68,400/mm^3, the reticulocyte count was 0.8 per cent. The serology was negative. The differential count showed 82 per cent monocytoid blast forms, 7 per cent lymphocytes, 6 per cent segmented neutrophils, 1 per cent eosinophils, 2 per cent bands, 1 per cent metamyelocyte and 1 per cent myelocytes.

A bone marrow examination showed 96 per cent monocytoid blast cells, 0.5 per cent eosinophils, 1.5 per cent neutrophilic granulocytes, 2 per cent normoblasts. The megakaryocytes were reduced in number. The bone marrow smears were literally flooded by blast cells closely resembling myeloblasts displaying oval or rounded nuclei with a fine network of chromatin strands in which usually 3 to 5 nucleoli were seen. The parachromatin was small in amount and pink or pale blue in color. The cytoplasm of these cells was reduced to a narrow band of pale blue color in which scattered azurophilic granules were occasionally found. These blast cells accounted for 96 per cent of the marrow elements within the smears, as well as in the sections. Marked depression of the other myeloid series was noted.

Mitotic figures, some of which were abnormal, were easily found. Megakaryocytes were reduced in number. Intracellular iron was seen in the narrow sections. Culture from the left ear showed growth of Pseudomonas aeruginosa and Staphylococcus aureus, coagulase positive. The swelling of the ear was thought to be of leukemic etiology and the patient received radiotherapy to the external ear. The patient received 40 units of ACTH intravenously per day. Two days after admission 200 mg of 6-mercaptopurine daily was started. Two weeks after admission methotrexate, 5 mg per day, was added and potassium prednisolone, 5 mg four times a day, was also given. Three days after admission the hemoglobin was 10.4 g/100 ml, the hematocrit 34, WBC 97,000/mm^3. The differential count was similar to the count noted on admission; however there were numerous smudge cells present. The platelets now were slightly decreased and one nucleated RBC was seen per 100 WBCs.

One week after admission the uric acid was 8.2 mg/100 ml. The WBC remained essentially unchanged. Two weeks after admission the WBC dropped to 6,800/mm^3, the hemoglobin to 8.8 g/100 ml, the hematocrit at this time was 28. The patient received two blood transfusions and shortly thereafter the hematocrit reading was 26. Two days later the patient received an additional two blood transfusions. The post transfusion hematocrit was 22. The uric acid was 4.4 mg/100 ml.

On the day prior to death the patient received an additional two blood transfusions. Four weeks after admission to the hospital the patient was found dead in his bed. During the entire hospital stay the patient was up and about, up to the time of his sudden death.

AUTOPSY FINDINGS: On entering the abdominal cavity approximately 1000 cc of clotted and unclotted blood were noted. The spleen showed a 4 cm long and 1 cm wide linear defect filled with blood clot on the anterosuperior aspect.

The spleen weighed 450 gm and was of soft consistency. On cut section it was noted that there were extensive small and large areas of hemorrhage throughout the splenic parenchyma. The liver weighed 3000 gm. The lymph nodes throughout the body were pale and enlarged and measured up to 2 cm. Microscopic examination of the spleen and lymph nodes showed the sinusoids filled with fairly large cells with vesicular nuclei. The cytoplasm of some of these cells showed specific granules. The liver, kidneys and testicles showed accumulations of leukemic cells. The bone marrow exhibited hypercellularity due to cells similar in appearance as the ones seen in the spleen and lymph nodes.

PATHOLOGIC DIAGNOSIS: Exsanguination from pathologic rupture of spleen in myelomonocytic leukemia, Naegeli's type, with leukemic infiltration of liver, kidneys, spleen, testicles, bone marrow, lymph nodes and left ear.

CASE #5

A 36-year-old white male noticed cervical lymph node enlargement in September, 1962. A biopsy of the lymph nodes revealed Hodgkin's disease of the granulomatous type. Radiotherapy to the mediastinum and cervical regions was carried out. In February, 1963, another cervical lymph node biopsy was performed at Wayne County General Hospital. The microscopic examination revealed Hodgkin's granuloma and tuberculous granulomata in which acid fast organisms were identified. The findings were verified by guinea pig inoculation.

The patient was treated with Isoniazid and Paraaminosalicylic acid. The patient was admitted for the last time in January, 1964, because of progressive weakness. On admission blood pressure was 108/70 mm Hg, the pulse rate 114 and the respiratory rate 20/minute. Laboratory examinations showed a hematocrit of 38, platelet count 7,500/mm^3, BUN 34 mg/100 ml, electrolytes within normal limits and WBC 2000/mm^3. The differential count showed 95 per cent polymorphonuclear leukocytes, 4 per cent lymphocytes and 1 per cent metamyelocyte. Bone marrow examination showed a hypocellular marrow with abnormal reticulum cells and osteoblasts. The total protein was 3.0 g/100 ml composed of 1.7 g albumin and 1.3 g globulin/100 ml. Roentgenographic examination of the chest showed extensive bilateral effusion and pulmonary congestion.

The patient received roentgenotherapy to the mediastinum, the cervical and retroperitoneal reions but not to the splenic region. He also reived corticosteroids and an alkylating chemoierapeutic agent Abbott A-20968.

Shortly before death the patient developed difculty in breathing and gastrointestinal bleeding. Vith whole blood transfusions and intravenous fluid was possible to keep the patient's blood pressure t 100/50 mm Hg. The patient expired 17 months fter the diagnosis of Hodgkin's disease had been stablished.

AUTOPSY FINDINGS: The abdominal cavity ontained 2200 ml of serosanguineous fluid and 00 ml of clotted blood was noted surrounding the leen, which weighed 200 gm. In the capsule of e inferior surface of the spleen a tear was noticed. n cut section several well circumscribed, pale ellow nodules measuring 0.5 to 0.7 cm in diameter ere noted in the splenic parenchyma.

PATHOLOGIC DIAGNOSIS: Pathologic rupure of spleen with massive intraperitoneal hemorhage due to Hodgkin's disease of spleen, lymph odes, and left lower lobe of lung.

DISCUSSION

Among the leukemias the greatest enlargement f the spleen is seen in myelogenous leukemia, specially in the chronic form. Krumbhaar[28] gave he average weight of the spleen in chronic myeogenous leukemia as 1,696 gm with a weight range rom 160 to 4,930 gm, for acute myelogenous leuemia as 437 gm, with a range from 86 to 1,650 gm. Ienke[29] gave the average weight as 2,072 gm, with range from 200 to 6,000 gm, for myelogenous leuemias of all types.

In lymphatic leukemia the enlargement is genrally not as great as in myelogenous leukemia. Krumbhaar's average values were 618 gm for hronic and 368 gm for acute lymphatic leukemia. Henke gave the average weight of the spleen in ymphatic leukemia as 950 gm, with a range from 125 to 4,210 gm. In rare types of leukemia the legree of splenic enlargement is variable. No usable figures were found.

In leukemia, splenic enlargement is almost invariably present, but rupture of the spleen is extremely rare, probably because an enlarging spleen n most cases seems to stimulate an increase of he reticulum network of the pulp and formation of connective tissue in the capsule, both of which give increased consistency to the organ. An increase n the reticulum network was noted by Eck.[10] On analyzing the reported cases of rupture of the spleen in leukemia, no predisposing factors were found, and most of the pathologic alterations noted in the ruptured spleens were also present in nonruptured leukemic spleens.

Among the reported cases, infarcts of the spleen were present in approximately 50 per cent. Splenic infarcts, often multiple, are found in about 50 per cent of cases of myeloid leukemia and in about 12.5 per cent of cases of lymphatic leukemias.[28] The etiology of these infarcts is somewhat obscure but may be attributable to increased viscosity of leukemic blood, leading to stasis and thrombosis; thrombosis may be followed by hemorrhage into the surrounding tissue.[11,30]

In addition, leukemia infiltrates within a spleen not only fill the sinusoids but also infiltrate the walls of arteries and veins, and the resulting endothelial damage may lead to thrombosis.[11,31] Thrombocytosis, not uncommonly observed, in chronic myeloid leukemia, also may favor thrombosis of vessels. Thrombocytopenia, resulting from crowding of the bone marrow by excessive leukemic cells, frequently observed in leukemias of all types, could explain multiple parenchymal bleeding occasionally seen in leukemic spleens.[31]

A number of authors, in discussing the subject of non-traumatic rupture of the spleen in leukemia, have termed the rupture "spontaneous" owing to the lack of obvious trauma. Lange[4] in his doctoral thesis, distinguished between spontaneous rupture without trauma and rupture following minor trauma, such as sneezing, coughing, defecation, purgation, or turning in bed.

In my opinion, this distinction seems irrelevant inasmuch as persons are constantly exposed to physiologic trauma, such as sneezing or coughing, every day from birth to death. The term, "spontaneous rupture," should be replaced by the term "pathologic rupture of spleen" in disease of the spleen such as leukemia or malaria, just as the designation of "pathologic fracture" of a diseased bone has replaced the older term "spontaneous fracture." The term *rupture of the spleen of unknown cause* is suggested for the rare cases of nontraumatic rupture of a spleen without known pathologic findings.[32]

RELATION TO TRAUMA: In none of the 36 cases was rupture preceded by obvious trauma. In 25, rupture of the spleen was the initial symptom of the leukemia. Usually the rupture was soon followed by death, and in all cases the diagnosis of leukemia or lymphoma was established by necropsy. In 15 cases, exploratory laparotomy established the presence of unsuspected splenic rupture, but splenectomy was followed by operative or postoperative death in one-third of the cases. Intraabdominal hemorrhage was usually massive. Upon surgical intervention or at necropsy, the volume of liquid or clotted blood found ranged from 33 to 3,500 ml (average 1,760 ml).

The weight of the spleen in the cases reviewed ranged from 400 to 3,600 gm (average 1,164 gm).

TYPE OF LEUKEMIA OR LYMPHOMA: Of the 36 cases of rupture, 16 were encountered in myeloid leukemia, 10 in lymphatic leukemia, four in leukemias or lymphomas of unclassified type, two in plasmocellular leukemia (possibly multiple myeloma), one in erythremic myelosis and three in Hodgkin's disease. Half of the cases of myeloid and lymphatic leukemia were classified as either acute or chronic forms.

AGE AND SEX: The average age of the patients with lymphatic leukemia was 50.1 years; of those with myeloid leukemia, 40.2 years. Of 36 patients 31 were male and five female.

DURATION AND EXTENT OF RUPTURE: In approximately half of the cases rupture was of immediate type or occurred within one stage, and was followed soon by death; in the remaining half, rupture was delayed for two or more days. The extent and location of the laceration varied from small capsular tears to complete separation of the organ into two parts. Tears along the convexity of the spleen predominated. Subcapsular hematomas were noted in more than half of the cases.

SYMPTOMS: Although the leukemia was undiagnosed in the majority of the cases, the patients generally had been ill, complaining of malaise, dyspnea, episodes of fever, anorexia, and loss of weight for periods ranging from days to a year.

HEPATOSPLENOMEGALY OR LYMPHADENOPATHY or both were present in most cases. Study of the peripheral blood and bone marrow usually established the diagnosis. The rupture of the spleen was usually accompanied by acute abdominal pain and dullness in the left epigastrium, and was followed by vascular collapse and shock, but the absence of a history of trauma frequently obscured the diagnosis and the need for surgical intervention was realized in less than half of the cases.

SUMMARY

Thirty-six instances of pathologic non-traumatic rupture of the spleen in leukemia or lymphoma were reviewed, including the present reports of a patient with lymphogenous leukemia, a patient with myelomonocytic leukemia and three patients with Hodgkin's disease. The occurrence of pathologic rupture of the spleen in Hodgkin's disease is recorded for the first time. In 25 of the 36 cases rupture was the initial event pointing to the leukemia. In approximately half of the cases the rupture was of immediate type; in the other half, it was delayed for two or more days after onset of subcapsular bleeding. In both forms, the mortality rate was high. The absence of a history of trauma frequently obscured the diagnosis, and the need for surgical intervention was realized in less than half of th cases. No satisfactory predisposing etiologic factor were found to explain rupture of the spleen in leukemia.

The term "pathologic rupture" of a disease spleen is suggested instead of "spontaneous rupture."

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(Continued on Page 114)

Plasmapheresis: An Innovation in Procurement Of Blood Components

ORIGINAL
SCIENTIFIC
ARTICLE

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An accompaniment of the tremendous increase in ood usage over the past two decades has been the alization that whole blood is not always the safest most effective form of transfusion therapy. Blood mponent therapy, the use of blood fractions to eet specific needs, helps solve the problem of ansfusing a sufficient quantity of therapeutically seful material while eliminating unnecessary risks the patient.

Judicious use of blood components not only bene-s the patient, it greatly increases the amount of ood and blood products which can be provided om the limited number of blood donors available a community. Application of the technique of asmapheresis has greatly enhanced the optimal tilization of blood components.

Plasmapheresis implies removal of a unit of blood om a donor, separation of the cellular elements by ntrifugation, and autotransfusion of the erythro-tes. Blood plasma is removed without reduction the donor's cell mass. The availability within the st several years of plastic transfusion equipment, pecially plastic blood collection bags, has simpli-ed plasmapheresis and has allowed the entire pro-edure, including separation of blood components, be carried out within a closed sterile system.

The principal factor limiting frequency of whole lood donation to eight-week intervals, with total onations limited to five times per year, is the re-eneration of hemoglobin. After a unit of whole lood, representing about 8 per cent of the blood olume, is removed from a healthy adult, total blood olume is restored within 36 hours by accelerated roduction of plasma proteins.

Hemoglobin reconstitution is much slower, with pretransfusion levels not approximated until three to four weeks after donation.[1] That blood plasma is more readily replenished than whole blood is not surprising. Replacement of plasma requires synthesis of 6 to 8 grams of protein for each 100 ml. About 4 grams of plasma protein and 16 grams of hemoglobin are needed, in addition to the cellular elements, for a similar volume of whole blood.

The rapidity with which blood plasma is reconstituted in the body in contrast to red blood cells allows greater frequency of plasma donation and therefore provides the biologic basis of plasmapheresis. In essence, plasmapheresis extends the rationale of component therapy into the donor room.

Historical Brackground

More than 50 years ago J. J. Abel[2] demonstrated that large amounts of plasma chronically could be withdrawn from the blood vascular compartment of an animal if the red blood cells were retransfused. His work provides a fascinating historical footnote. Abel,[3] former Professor of Pharmacology in The University of Michigan, became part of the first faculty at the Johns Hopkins Medical School in 1893. This physician-chemist is best known for isolating epinephrine from the adrenal medulla and for developing liver and renal function tests using phthalein derivatives. His research and influence as a teacher and editor were fundamental in forging the shape of modern medicine. Yet his interest in plasmapheresis was strangely of another era, for he was attempting to develop improved techniques of bloodletting in the tradition of the 19th century venesectionist.

Nevertheless, it should be noted that Abel suggested that plasmapheresis could increase yields from hyperimmune animals used as commercial sources of antitoxic sera. Furthermore, he foresaw the advent of blood banks, still three decades in the future, when he postulated that "a supply of human corpuscles might possibly be kept . . . in operating rooms for rapid infusion in emergencies that could otherwise prove fatal."[2]

Advances in sterile technique, in control of the clotting processes, and in the knowledge of the factors that govern compatibility of the blood of different persons had yet to be made.

Human plasmapheresis was begun in 1950 by Grifols-Lucas[4] working in Barcelona, Spain. He

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used this technique in an effort to solve the problem of an inordinately greater need for plasma than for packed red cells on the transfusion service. He selected a small group of regular blood donors to be plasmapheresed. Each of these donors initially donated one unit of whole blood. This was collected in standard acid-citrate-dextrose (ACD) solution, promptly centrifuged, 200 ml of plasma was removed, and the packed red blood cells were refrigerated. At the next donation, and at weekly intervals thereafter, another unit of whole blood was withdrawn, followed by retransfusion of the donor's red blood cells drawn the previous week.

Therefore, each donation after the first was equivalent to the loss of approximately 200 ml of plasma. Advantages of this procedure were immediately apparent. Either fresh or stored plasma could be supplied in quantity with a most economical use of donors. Moreover, because the number of donors was small, the hepatitis risk was greatly reduced.

There were also significant disadvantages. First, since the blood was collected in glass bottles it was impossible to remove the plasma without some risk of bacterial contamination. Second, although Grifols-Lucas showed that healthy adults could donate 200 ml of plasma each week for at least one year without reducing total plasma protein or hemoglobin concentrations, and without any other apparent ill effect, limits for the total amount of plasma removed and the frequency of plasmapheresis had yet to be established to insure donor safety.

Safety of Plasmapheresis for the Blood Donor

Of utmost concern in the use of this technique is donor safety. Previous workers have shown that removal of one liter of plasma each week for as long as a six-month period produces no obvious effect on the donor's serum proteins.[5] Therefore, the standards of the American Association of Blood Banks set one liter per week as a maximum volume of plasma to be drawn.

Plasmapheresis was instituted at The University of Michigan Medical Center Blood Bank early in 1963. The initial objective was to provide fresh-frozen plasma for use in treatment of patients with Hemophilia A. Donors to be plasmapheresed were selected from the regular blood donor pool. Each had made at least six previous donations of whole blood, was of blood group AB, lacked atypical antibodies, had a normal AHG level, was available for careful medical follow-up, and was willing to take part in a somewhat experimental program.

These donors have been plasmapheresed to meet the needs of about 50 hemophiliacs and numerous patients with other clotting factor deficiencies Generally, they have been bled twice each week two units of plasma being withdrawn at each donation. One of these donors has given in excess of 50 units of plasma. Several others have contribute between 200 and 300 units. Our donors have bee followed by repeated physical and laboratory determinations, including complete hemogram, platele count, serum iron and iron-binding capacity, seru electrophoresis (cellulose acetate method), an serum immunoelectrophoresis.

Thus far these studies constantly have been within normal limits. All of the original plasmapheresi donors, and those subsequently added to the expanded program, have remained in excellent health

One donor was dropped from the fresh froze plasma program, after giving 154 units of plasma because he spontaneously developed anti-Lewis and ^{b} antibodies. He is still being bled periodicall and used as a source of typing serum.

During the past year and one-half we have increasingly used plasmapheresis to obtain platelets either as platelet-rich plasma or platelet concentrates. This has greatly facilitated the ability of th blood bank to meet the greatly increasing demand for platelets related to open heart surgery an maintenance of thrombocytopenic patients.

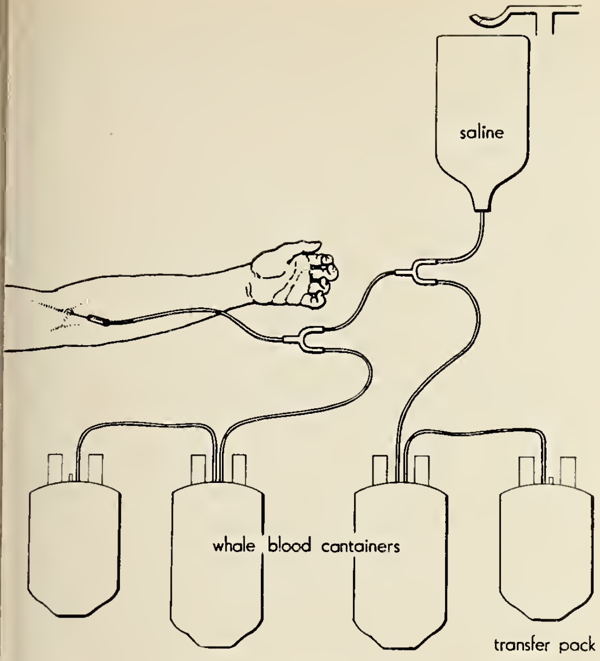
A small group of platelet donors, who satisf regular donor requirements and who are readil available at all hours of day and night, have bee plasmapheresed for platelet-rich plasma at th maximum rate used for plasma donation. Thei platelet counts, hemograms, and blood chemica determinations also have remained uniformly normal, even when frequency of donation has bee increased to three times per week.

Because we have used relatively few donors an have plasmapheresed them frequently, we have undoubtedly exceeded the amounts of plasma tha would ordinarily be drawn from a donor unde routine blood bank conditions. The prospectiv donor, we believe, can be assured that plasmapheresis within the limits set by the American Association of Blood Banks is as safe as routine bloo donation.

Practical Aspects of Plasmapheresis

The principal advantages of plasmapheresis ar two-fold. First, it is possible to procure a volum of plasma at a single donation equivalent to tha present in two units of whole blood. Second, sinc this plasma can be withdrawn at very frequen intervals, donors can be used much more efficiently

Two secondary advantages should also be noted Since the plasmapheresis donors utilized have bloo group AB, their plasma contains no iso-antibodie in the ABO system, and since all of these plasm donors are screened for atypical antibodies befor



eing used as plasma donors, no crossmatching of nis plasma is necessary.

Moreover, since we are using a small group of onors to meet our plasma requirements, the hepatitis risk is greatly reduced.

Although most hospital blood banks will find this chnique most useful to provide platelets or freshrozen plasma, it can also be used to prepare any ther plasma fraction, including serum albumin, brinogen, and immune globulin. The technique as also been used to obtain large quantities of lood typing sera from persons sensitized to low ncidence blood group antigens.

As was noted above, plasmapheresis was initially mployed in this hospital to obtain the large olumes of fresh or fresh-frozen plasma needed to reat deficiencies of plasma clotting factors. Since ll of these clotting factors except AHG and factor V can be supplied from routinely stored bank lood, and since isolated factor V deficiency is exremely uncommon, fresh and fresh-frozen plasma s most useful in treating patients with deficiency of actor VIII (Hemophilia A). The amount of lasma necessary to elevate a patient's factor VIII o hemostatic levels is in the order of one-third of his circulating plasma volume. While it would be impossible to give enough AHG in whole blood to achieve therapeutic levels without greatly overtaxing the cardiovascular system, with fresh or fresh-frozen plasma such levels can be achieved.

Plasmapheresis technique has made it possible to supply the great quantities of platelets used in our hospital without significantly depleting our pool of blood donors. Fresh whole blood has been the traditional means of supplying platelets for transfusion. However, a greater concentration of platelets per unit volume of transfused plasma can be attained by use of platelet-rich plasma or platelet concentrates prepared by differential centrifugation.

Persons with prolonged and severe thrombocytopenia may require hundreds of units of platelets administered over weeks or months to maintain hemostatic levels. (A unit of fresh whole blood contains about 1×10^{11} platelets. This number of platelets is enough to increase the peripheral platelet count about 15,000/mm^3/square meter of body surface. Only about one-third of these transfused platelets will survive 48 hours.)[6]

Plasmapheresis for platelet-rich plasma or platelet concentrates has made possible such massive and long-term platelet transfusions, as in patients with acute leukemia and hypoplastic anemia, and it has been found that such transfusions reduce the incidence and severity of hemorrhagic complications. Platelet preparations also have been employed effectively in patients with transient platelet insufficiency, such as that resulting from massive transfusion with stored bank blood or from cardiopulmonary by-pass.

Conclusions

During the past several years plasmapheresis has evolved from an experimental technique to a routine blood bank procedure which can greatly increase the availability of blood and blood products from a limited donor pool. Only a minimum of special equipment is needed, and this is readily available commercially. Technical procedures are well worked out and can easily be performed by a blood bank technologist after minimum instruction. Potential hazards to the plasmapheresis donor are no greater than the minimal risk of routine blood donation.

The development and application of plasmapheresis techniques has been in response to the press of necessity. The use of blood and blood products is fast approaching the limits imposed by conventional blood banking techniques and donor recruitment.

After two and one-half years' experience, we believe that plasmapheresis techniques are of great assistance in a blood bank or blood transfusion service with a limited donor pool to provide the

ABSTRACT: The use of blood and blood components is fast approaching the limits imposed by conventional blood banking techniques and donor recruitment. Plasmapheresis is a practical and safe alternate form of blood donation that can greatly increase the capacity of a blood bank or transfusion service to provide the materials needed to practice effective blood component therapy.

materials needed to practice effective blood component therapy.

Appendix

Plasmapheresis Technique Used in The University of Michigan Medical Center Blood Bank

EQUIPMENT:

1. Single, or double, plasmapheresis double blood pack*
2. Plasma extractor*
3. Y-recipient set*
4. Hemolator*
5. 500 ml, 0.9 per cent sodium chloride (for intravenous infusion)
6. Servall RC-3, or comparable, refrigerated centrifuge.

PROCEDURE FOR OBTAINING FRESH-FROZEN PLASMA

1. Assemble tubing of plasmapheresis bags and saline infusion bottle as shown in Figure 1. (The illustration indicates the setup for a two-unit donation.)

2. Draw 500 ml of whole blood into one recipient bag, using hemolator to acclerate donation.

3. Disconnect this bag with its attached transfer pack.

4. Draw blood samples into test tubes for subsequent performance of blood grouping and typing, serologic test for syphilis, atypical antibody screen, and total serum protein. (Because only AB donors are used, and because sera are screened for atypical antibodies, we do not prepare a serum pilot tube.)

5. Begin intravenous infusion of 0.9 per cent saline to maintain patency of vein and tubing.

6. Spin the whole blood in refrigerated centrifuge (Servall RC-3, at 4°C, for six minutes, at 5,000 r.p.m.).

7. Using plasma extractor, express maximum volume of plasma into transfer packs, taking care to avoid displacing cellular elements into plasma. (The yield is 250-290 ml.)

8. Store plasma at –30°C or lower.

9. Attach packed cell mass to Y-recipient set, re-suspend cell mass with saline from infusion bottle, and administer to donor as rapidly as feasible.

10. If a second unit of plasma is to be drawn (double plasmapheresis), repeat the above procedure using the second recipient bag and transfer pack.

Approximately 75 to 90 minutes are required for donation of two units of plasma. The plasma has a shelf life of one year for use as a source of anti-hemophilic globulin.

PROCEDURE FOR OBTAINING PLATELET-RICH PLASMA OR PLATELET CONCENTRATE

1-5. Same as above.

6. Spin the unit of whole blood in refrigerated centrifuge. (Servall RC-3, at 4°C for three minutes, at 3,500 r.p.m.) The speed and duration of centrifugation should be adjusted by determining maximal platelet yields under various conditions.

7. Using plasma extractor, express 230-240 ml of platelet-rich plasma into transfer pack.

8. If platelet-rich plasma is the desired product, the red cell mass is attached to the recipient set, re-suspended, and infused as in step nine above.

9. If platelet concentrate is desired, recentrifuge the platelet-rich plasma, leaving the packed red cells attached. (Servall RC-3, at 4°C, for five minutes, at 4,000 r.p.m.) The speed and duration of centrifugation should be adjusted for each machine to achieve maximal yield.

10. Using plasma extractor, express platelet-poor plasma back into recipient bag containing cellular elements. Allow approximately 40 cc of plasma to remain in transfer pack to re-suspend the platelets.

11. Attach the resultant unit of platelet-poor whole blood to recipient set and administer to donor.

The platelet product should be transfused as soon as possible. Optimal results are achieved with administration within six hours of donation. Platelet counts are performed on donors before each platelet plasmapheresis.

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RUPTURE OF SPLEEN

(Continued from Page 110)

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The Meeting Ground Of Psychiatry and Religion

ORIGINAL SCIENTIFIC ARTICLE

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Since I am neither a psychiatrist nor a clergyman, I must disqualify myself at once as an expert in the two disciplines mentioned in the title of this discussion. This makes things a little easier for me and, I hope, for you because most of you are in the same position.

We can talk in a more uninhibited way about the obvious meeting ground of psychiatry and religion—the patient with a problem—without danger of losing our amateur standing.

What makes our profession so uniquely thrilling and challenging is that we are dealing with human beings—people who possess body, mind and soul. Probably 95 per cent of the formal education we have had to become physicians has been directed toward a knowledge of the body and how to correct the disorders arising in it. Precious little time is allotted in the medical school curriculum to the human spirit—the most elusive, most unpredictable, most illimitable and wonderful thing of which we have any knowledge.

If it were not for the human spirit our preoccupation with broken bones, diseased hearts, cancer—and all the rest of it—would have no point.

How well most of us, as physicians, will do in dealing with the mental and emotional problems of our patients will depend not upon what we learned in the universities, but in the kind of attitude we developed in early childhood and the growing years toward the world about us.

Have we reached a maturity in which we see both ourselves and our fellow human beings as children of God with a divine spark in all of us which makes life meaningful and rewarding? If we have perhaps we can help our patients with the deep inner conflicts of which functional physiologic aberrations are an outward manifestation. But it is quite important for us to keep our perspective, realizing that we are amateurs, and to try to recognize those cases of mental and emotional illness which need the specialists in the healing team—namely, the psychiatrists and the clergymen.

Doctor Rhoads is Professor of Medicine, Northwestern University School of Medicine, and Chairman, Department of Medicine, Chicago Wesley Memorial Hospital. He delivered this paper recently to the Kalamazoo Academy of Medicine.

C. W. Hall, in his introduction to Young and Meiberg's excellent book, "Spiritual Therapy,"[1] summarizes Young's very practical concept of comprehensive healing as follows:

"The *physician* says . . . 'Here is a body that is sick. I will address myself to that sickness, and with the latest drugs and surgical techniques I will make this body well.'

"The *psychiatrist* says . . . 'Here is a mind with an anxiety that has made the patient physically and mentally ill. By analysis I will help him gain insight into his problem, and by drawing upon his own resources, he can help heal himself.'

"The *minister* says . . . 'Here is an immortal soul, whose sick body and disturbed mind have defeated him as a person. By giving him love and understanding, and by pointing him to resources outside himself, I will help him get beyond his body-mind disorders to their underlying cause; his sense of disharmony with himself, his fellows and his God.'

"*Together* all members of the healing team say . . . 'Here is a man who is body, mind and soul. His whole health is the sum of the health of the three. Only by working together, each in his own specialty, can we heal the whole man.' "

It is heartening, indeed, that the artificial fences between the various members of the healing group are coming down; so that each can see the value of the contributions of the other, realizing that these contributions should complement each other rather than be mutually exclusive.

The Physician's Role

We, as physicians, have long been aware that physical disorders underlie many emotional problems and that no amount of psychiatric or religious counselling will get the patient well until the physical disorders are dealt with.

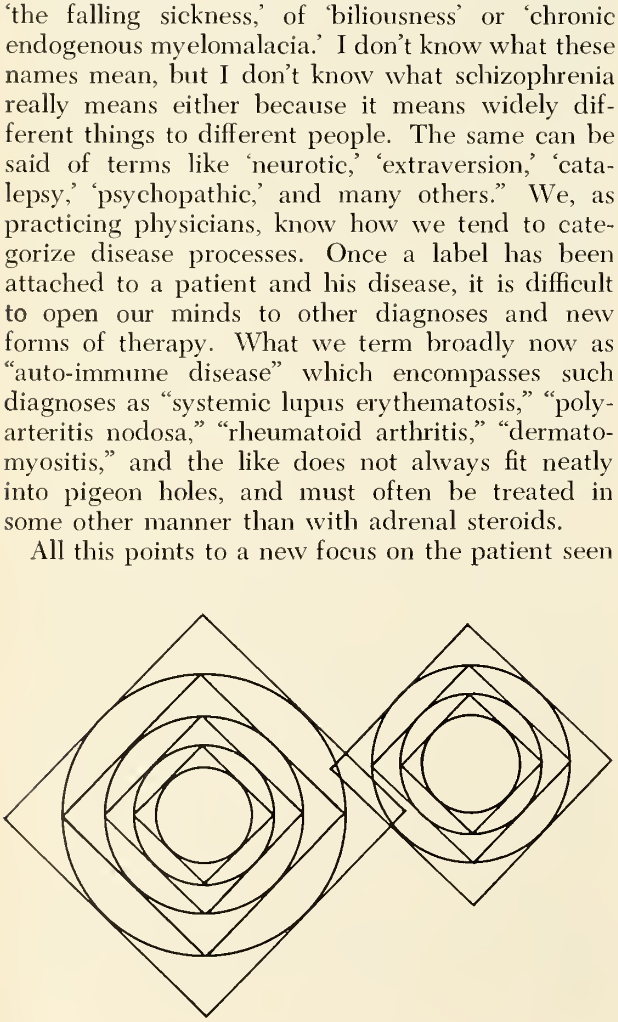
For instance, the irritable, sensitive patient with active ulcerative colitis may be suffering emotional conflicts, but these will seldom be amenable to psychotherapy until we get him over his distressing diarrhea and abdominal cramps.

In the same way patients with the recurring periodic distress of peptic ulcer, or those with extreme hypothyroidism or anemia, will not regain a happy outlook, regardless of how much spiritual therapy they receive, until we correct these underlying physical troubles. At the Menninger Clinic, as, indeed, in all good institutions for the care of mentally ill patients, a thorough physical examination precedes or accompanies the probing into the patient's life history and emotional reactions.

These eminently practical psychiatrists have recognized some of the growing pains of their relatively young specialty and have attained a point of view which we amateurs can more readily understand.

I found Karl Menninger's article in the *Saturday Evening Post*[2] very reassuring. In it he points out that the terms psychiatrists use can hurt people, and sometimes do. "Instead of helping to comfort and counsel and heal people . . . which is the goal of psychiatry . . . the terms often cause despair. Words like 'schizophrenia,' 'manic depressive,' and 'psychotic,' for example, frighten patients and worry their anxious relatives and friends. They also affect the psychiatrists, leading them back to the days when mental illness was thought to be made up of many specific "diseases" and when each "disease" bore a formidable label and a gloomy prognosis. Schizophrenia is no more a clear cut disease than 'the falling sickness,' of 'biliousness' or 'chronic endogenous myelomalacia.' I don't know what these names mean, but I don't know what schizophrenia really means either because it means widely different things to different people. The same can be said of terms like 'neurotic,' 'extraversion,' 'catalepsy,' 'psychopathic,' and many others." We, as practicing physicians, know how we tend to categorize disease processes. Once a label has been attached to a patient and his disease, it is difficult to open our minds to other diagnoses and new forms of therapy. What we term broadly now as "auto-immune disease" which encompasses such diagnoses as "systemic lupus erythematosis," "polyarteritis nodosa," "rheumatoid arthritis," "dermatomyositis," and the like does not always fit neatly into pigeon holes, and must often be treated in some other manner than with adrenal steroids.

All this points to a new focus on the patient seen as a whole person, not as an individual with a single disorder which, because it fits into the realm of our particular discipline, makes us want to pul him inside our own fence.



The Psychiatrist's Role

There can be no doubt that modern psychiatry beginning with the studies of Freud in the 1880's has widened the horizons of religion. Granger Westberg[3] has pointed to psychiatry's discovery of the dimensions of the unconscious mind as it affects human behavior, the way in which the sum total of a person's experiences influences all of the subsequent choices he makes.

This has helped ministers to connect religion to life in a more meaningful way. Ministers have been taught the value of "relating" to their parishioners and of prolonged conversations with them, conversations in which deep inner conflicts are brought to the surface; so that they may be recognized and dealt with. In this way a different concept of sin and why people become sinners has been established. Psychiatry has taught ministers to get back to the old concept, abandoned to some extent in the scientific era, that decisions are made not on the basis of intellectual concepts alone, but on the basis of emotional drives as well.

In Westberg's opinion the whole Protestant church has been "smoked out" by psychiatry in its outlook on sex—changing its view that sex is a curse, to one in which sexual experience in marriage, as a mature expression of love, is regarded as a divine blessing to be enjoyed. Psychiatry has also touched off a new appreciation of private confession, validating it as a means of getting rid of guilt feelings and starting off with a more hopeful outlook as one returns to life's conflicts.

Linn and Schwartz[4] have pointed out that ministers have become aware that mental illness may assume a religious guise. Hyper-religiosity may become grotesque and extreme, easily recognized by the psychiatrist as an expression of great insecurity. There may be a self-righteous separation from the world rather than whole-hearted solidarity with one's fellow men. Sometimes misguided ministers may condone "compulsive legalism" in church members, manifesting itself in strict adherence to church rules, but by-passing a moral outlook which fosters the creative cooperation of impulse and conscience.

These are examples of the way in which psychiatry and the other sciences have helped the church outgrow its over-emphasis on dogma and forms of worship, and to make itself more useful in the lives of men.

Role of the Clergy

But this is a two-way street. Perceptive psyhiatrists know that to emancipate man from his nxieties and to restore meaning and dignity to is life, something more than an awareness of his motional problems and their probable cause is re-uired. The basic issue of man's relationship to ie universe in which he lives—in other words, to od—must be faced. It is here that religion must ke over, if lasting benefits from psychiatric coun- lling are to be achieved.

To quote again from Linn and Schwartz, "Too iany people even now take the objective attitude f the psychiatrist—an attitude he maintains in the nalytical hour—as a prescription for a way of life, ho believe that to do away with frustration is to o away with mental illness. For them, anxiety, uilt, sadness, anger, all are pathological—and tran- uility nothing less than the ultimate good. The eligious leader should not stand for 'tranquility at ny price.' He must keep alive a capacity for judgment, stir the conscience." In other words, if the sychoanalyst has been successful the patient hould become capable of mature decisions, will ecognize that the moral code of the Western Vorld, as embodied in its great religions, consti- utes the best guide for getting along with his ellow human beings.

The clergy should, of course, re-enforce this con- ept. But if religion is true to its purpose it will ffer much more than a set of rules to live by. It vill unlock the spirit and let it see the majesty of he universe of which all of us are a part. It will nake known the divine power to lift us up and to nake us responsible participants in the great adventure of life.

Everyone seriously interested in the problem we re discussing today should re-read the story of Job.

You will recall that after the three old friends of Job had commiserated with him and were unsuccessful in relieving his depression, the young man, Elihu, became impatient with all of them and said, "Let days speak and many years teach wisdom. But it is the spirit in a man, the breath of the Almighty, that makes him understand."[5] He then goes on to extol the mighty works of God and to rebuke Job for setting his own puny judgments against those of his Maker. You will recall that finally, "The Lord answered Job out of the whirlwind, 'Who is this that darkens counsel by words without knowledge- Gird up your loins like a man, I will question you and you shall declare to me. Where were you when I laid the foundations of the earth? Tell me, if you have understanding? Who determined its measurements—surely you know! Or who stretched the line upon it? On what were its bases sunk, or who laid its cornerstone, when the morning stars sung together and all the sons of God shouted for joy?[1]" For two chapters more the discourse goes on and Job is allowed to see his own problems against the broad tapestry of God's mighty works. Once more he receives the command, "Gird up your loins like a man; I will question you and you declare to me . . . etc." At last, Job capitulates and eventually admits, "I had heard of thee by the hearing of the ear, but now my eye sees thee."

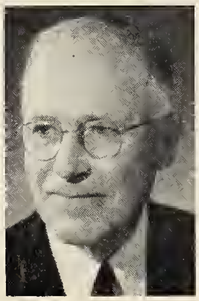
This emphasis that it is the destiny of every human being to play his part in this mighty drama if he will only "gird up his loins," come to grips with the realities of life and learn to love his fellow man is religion's contribution to man's happiness.

Joshua Liebman, in his book "Psychiatry and Religion,"[6] says, "Psychiatry . . . cannot hope to grapple with the profoundest issues of human destiny. . . . What the sages of Israel meant by God was the Creative Power, Process and Mind in the universe." He quotes the Zohar, the great source book of Jewish mysticism. "There are gates in the world by which God is known—gates of history, and of conscience, and of science . . . while a full knowledge is beyond the reach of any human being, the Holy One, blessed be He, makes himself known to each one of us according to the measure of his understanding." In a passage further on, he says, "The atheist is really an idolator worshipping at the shrine of his own little mind."

I quote from the important work—Psychiatry and the Bible, by Carroll Wise[7]—"Man cannot get away from God . . . he may substitute other words for God, but he cannot escape from the fundamental reality that creates, undergirds and sustains all life . . . if he pierces through the demands made on him by other persons to the demands which are rooted in the very nature of life itself and to which no man can add or subtract—if he gains such insight he will discover a moral order in life as certain as the natural order which science reveals."

It is only by getting the big view, in which the picayune worries and tawdry considerations that clutter up our lives are seen in true perspective, that we can see the worth and dignity of ordinary people at everyday jobs.

All of us are aware of the tremendous debt we owe modern psychiatry for its development of



THE AUTHOR

Paul S. Rhoads, M.D.

techniques to reveal the secrets of the subconscious mind and make patients aware of their problems. Also we know of the potentialities of religious counselling for putting meaning into the lives of men. But we must face realities. These are that more patients come to ordinary physicians, like you and me, than to psychiatrists, when they have emotional problems, and possibly as many seek help from us for such problems as go to their ministers.

Let us consider a few of the kinds of problems we encounter most commonly.

Alcoholism

Salter, in his text on Pharmacology says men use and abuse alcohol because life hurts too much. For some extremely timid persons the freedom from inhibitions which alcohol gives is seen by them as almost a requirement for communicating comfortably with other persons. Others are simply bored, and alcohol helps them put up with life.

I recall a conversation with one of my patients several years ago. This man had not been examined at our office for nearly two years. When he came I found he was grossly overweight, walked with a flapping sort of gait, complained bitterly of pains in his arms and legs—obviously due to alcoholic or diabetic neuritis, or both. I said, "George, you have had a good education; you have a profitable business; you know you have diabetes . . . why do you keep on drinking too much?" He was a forthright person, and answered, "You know about the business I inherited from my father. I go to the office about 10 in the morning and I'm through by 2:30 in the afternoon. That is all that is needed. What is there to do from 2:30 on? We belong to a crowd that has a cocktail party in somebody's apartment nearly every afternoon. The parties are so damned stupid you couldn't stand being there if you didn't get drunk!"

I was never able to get this man interested in church but eventually was able to persuade him to stop drinking by repeatedly appealing to his intelligence. But the combined vascular and hepatic damage from the years of uncontrolled diabetes and continued drinking eventually caused his death.

Other persons become alcoholics because they are lonely. They cannot create good rapport with the people with whom they come in contact. I am sure all of you, like me, have a great many patients who see their physician as sort of a paid friend. They know of no one else to whom they can bring their troubles; so they seek the doctor, complaining of a real or imagined physical disorder in the hope that he will lend a sympathetic ear to the real problems that frustrate them.

I am naive enough to believe that most alcoholics could be straightened out if it were possible for one person to spend sufficient time with them to make them know that at least one single person believed they were important people who were worth rehabilitating.

I think of three of our patients who have instructions to call one of my associates or me, day or night, regardless of where they are in the country, if they feel they are about to break over and take a drink. All of these patients have acted on these instructions; all have slipped at least once and had to be straightened out again; but all have been able to stay on the job and two have become active in their local churches. This, of course, is analogous to the Alcoholics Anonymous approach, which is, in my opinion, a form of very practical religion.

Adolescent Problems

Young people frequently are brought to physicians because they suddenly seem to lose interest in things and slip badly in their school work. They are sent home from high school or college on the advice of their school counsellors. The dismayed parents bring them to us because they feel some physical disability must be the cause.

We dutifully look for thyroid disturbances, infectious mononucleosis, hepatitis and the other common ailments that afflict this age group; but, more often than not, find that the problem is one of adolescent adjustment to the difficult problem of growing up. As Liebman puts it, attainment of maturity requires that people give up the infantile look at the world as a "bottle of milk" rewarding them for being good or a "punishing ruler" which will get in its licks if they are bad. In the "awkwardness of conscience" that some young people find difficult to outgrow, guilt feelings become very burdensome, and are dealt with in bizarre ways—or not dealt with at all.

Sometimes experiments with sex or alcohol are such that a sense of guilt is warranted, more often minor problems have caused an exaggerated degree of self-reproach. Regardless of the degree, these young people are needing terribly to talk to someone they can trust. If the inquiry into their physical symptoms has been gentle and tactful they may find the doctor a friend in whom they can

Proceedings Available

Copies are still available of the Proceedings of the Congress on Mental Illness and Health sponsored by MSMS in Detroit. Interested physicians may obtain a copy for $1.00 by writing to MSMS, 1200 West Saginaw, East Lansing.

bstract: All of the disciplines concerned with people in physical or emotional rouble are beginning to realize that they must consider the "whole person" if heir efforts are to succeed. Proper teamwork demands that physicians undertake to orrect metabolic, vascular, and infectious disorders which contribute to the patient's nhappy state. The psychiatrist must evaluate the emotional conflicts that cause or nhance illness and help the patient gain insight into his problem. The minister's role, n cooperation with the psychiatrist and physician, is to point out to the patient esources outside himself which will lend order and significance and direction to his ife. Only by thus working together can the members of the healing team be maximally effective.

onfide. He may be able to point out from his peronal knowledge that the parents of the frustrated oung person are pretty human and understanding fter all, and even the minister is not an ogre. Sometimes, by simply listening sympathetically to the problems and pointing out the ways people can be important on campus without compromising their morals or loyalties, the family doctor can be of considerable help.

Marital Problems

Probably the physician is involved in problems hat arise between husband and wife more often han the psychiatrist and minister. This is, no doubt, because he has been the consultant of both on medical problems. He knows something of the habits and outlook on life of both. He can recognize in sick headaches, irritable bowel syndromes, precordial distress and other somatic complaints a psychic component that may have its origin in marital difficulties.

Contrary to popular opinion, most doctors know that sexual maladjustment is not usually the major cause of marital conflicts. Selfishness and failure to cut the umbilical cord that ties one or both of the marriage partners to their families are more apt to be at the bottom of the trouble.

Detailing all of the various areas of discord that make married people sick just because they are married cannot be done in this communication. But if the physician wants to make a correct diagnosis and suggest a cure he must ferret them out. Maybe the husband insists on dating his secretary; maybe the wife neglects her household duties for golf and bridge; maybe there is mother-in-law trouble. These are practical problems just as real as sore throat and diabetes and nephritis. Their solution may be in the province of the psychiatrist or the minister, or both, but it is the physician's job to discover the cause of the symptoms by patient listening and prodding.

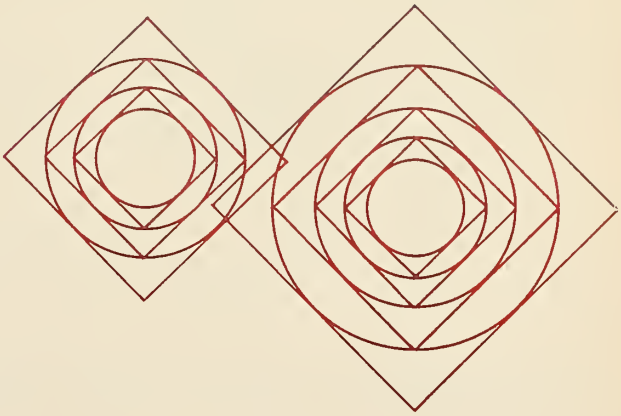
Usually, if he has made friends with the patient and these valuable colleagues he can guide the patient into their hands. But if this is not possible he must do what he can to point out that both marriage partners thought the other was pretty wonderful at the time they were married. If they will do some hard thinking they may find out that they are childish and selfish in their attitude toward each other, and that if they both work at being more charitable the marriage can succeed.

These are samples of the kinds of problems that confront us every day. Even if we are amateurs we usually can recognize persons with true or potential psychoses and those with deep-seated character disorders. Such persons clearly should be referred to psychiatrists if it is possible to do so.

The vast majority of patients who need counselling of some sort will stay in our hands whether we like it or not. There simply is not enough time to deal adequately with all of them, even if we were properly prepared to do it. I try to send those with distorted thinking to a psychiatrist if one I trust is available and if the patient can afford it. Those who seem to me to be in the deepest need of spiritual help I send to the clergymen—if the patient will go. I am sure you do the same.

What to do about the others?

I remember the statement of Paul Tournier in his book—"Guilt and Grace."[8] "They tell us about their illnesses, their symptoms, their conflicts; in fact, everything they can describe clearly. But they all expect from us something more than our technical attention; not only our sympathy, our personal solicitude or our encouragements, but also, in whatever form it may be and perhaps quite un-



obtrusively, a beam of the divine grace which alone can efface guilt."

How are we to have this "beam of divine grace"? I am sure I do not know, but I am equally sure that what is more important is to try to see it in the person we are trying to help. For it is always there if we have enough patience and understanding to find it.

As physicians we cannot side-step the task. Perhaps the best we can do is to fall back on the simple but profound teachings of our early days, such as the Sermon on the Mount,[9] recalling such verses as:

> *"For where your treasure is, there will your heart be also."*
>
> *"Judge not that you be not judged. For with the judgment you pronounce you will be judged, and the measure you give will be the measure you get."*
>
> *"Ask and it will be given you; seek, and you will find; knock, and it will be opened to you."*
>
> *"So whatever you wish that men would do to you, do so to them; for this is the law and the prophets."*

If we feel uncomfortable in this role of counsellor that is so frequently forced upon us, it is heartening to know that our valuable allies, the psychiatrists and clergymen, are ready to join with us in treating the deep needs of the whole man.

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Were Lincoln Living Today

By Frank Beadle,
State Senator of St. Clair

Had Lincoln been living today, round these nooks,
The Rotary Club would have furnished him books,
The Lion's Club, a reading lamp would provide,
Kiwanis, pens and paper, all put by his side.
The Optomist Club for his cabin, wood floors,
The Business Women, to be saving him chores
Of splitting up wood, would send coal for fuel.
A school bus would take him a riding to school.
And not only that, but there'd be some assurance
He'd not have to work for Child Labor insurance.
A kindly philanthropist to further his knowledge
Would a scholarship give, to send him off to college.
A case worker would see, with some sort of bounty
His dad got a check every month from the county.
There would subsidies be, for crops he did grow
He would grow anyway, and likewise it would show
There'd be subsidies too, they would see that he got
For not raising some crops that he somehow forgot.
And all other benefits are being passed down
From down there in Washington, now called Boy's Town.
I wonder a bit, in our day and our age,
There's many Abe Lincolns would have come on the stage.
Great leaders to be with a zest and a fire
But raised in a way has killed off their desire.
Responsibility, initiative, for which Lincoln stood
Could today mean so much for the great common good.
The moral, I see, and should set us thinkin'
If today Lincoln lived, there would be no Abe Lincoln.

Wm Beaumont
HIS ASSOCIATION WITH MEDICAL EDUCATION

Thanks to an exhibit by three MSMS members, the delegates at the AMA Clinical Convention in Philadelphia learned more about the contributions of Michigan's William Beaumont, M.D. A gastroenterology exhibit was developed by Alfred H. Whittaker,

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There have been 540 major new drugs made available since 1941 in the United States; nearly two-thirds of these originated in the U. S.

lo Registration ee for Maternal Velfare Conclave

Advance registrations are very ncouraging for the Fifth Annual lichigan Conference on Maternal nd Perinatal Welfare, sponsored by ISMS at Flint, March 24-25.

Preliminary programs have been ailed to every member, and efforts re being made to involve other in-rested medical personnel in the vent at the Pick-Durant Hotel.

There will be no registration fee r the conference; the only cost will e for transportation, lodging and eals.

Reservations should be sent to ISMS, 120 West Saginaw, East ansing.

* * *

THE FOLLOWING SPEAKERS ave been firmed up by the MSMS laternal Welfare Committee, Wilam W. Jack, M.D., Grand Rapids, hairman:

IARCH 24 LUNCHEON:

Welcome by officials of the MSMS nd Genesee County Medical Societies.

IARCH 24 AFTERNOON:

M. Edward Davis, M.D., Chairan, Department of Obstetrics and ynecology, University of Chicago chool of Medicine (subject to be nnounced);

T. N. Evans, M.D., Chairman, epartment of Obstetrics and Gyneology, Wayne State University ledical School, on "Induced Aborion and Maternal Mortality";

James L. Wilson, M.D., Chairan, Department of Pediatrics and ommunicable Diseases, University f Michigan Medical School, on The Respiratory Distress Synrome";

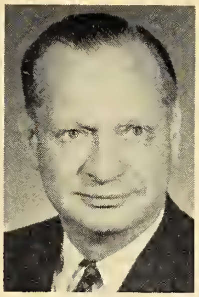
James B. Arey, M.D., Professor of athology, Temple University (subect to be announced).

IARCH 24 EVENING:

Reception and Banquet.

David Treat, Sunnyvale, California, family-education consultant on "Educational Re-Tooling for Family Life."

TREAT



PHILLIPS

MARCH 25 MORNING:

James V. Neel, M.D., Chairman, Department of Human Genetics, University of Michigan Medical School, on "Genetic Counseling for the Practicing Physician";

Otto C. Phillips, M.D., Pittsburgh, Chairman, Maternal Welfare Committee, American Society of Anesthesiologists (subject to be selected);

Paul V. Woolley, M.D., Chairman, Department of Pediatrics, Wayne State University Medical School, on "Syndromes in the Nursery—A Photographic Display";

Gordon C. Brown, M.D., Professor, Department of Epidemiology, University of Michigan School of Public Health, on "Serologic Study on Rubella: Incidence and Immunity."

MARCH 25 LUNCHEON:

No speakers. Adjournment about 1:30 p.m.

Pick Chairmen for House Committees

Chairmen and committee members have been appointed for the 1966 MSMS House of Delegates committees by Speaker James J. Lightbody, M.D., of Detroit.

Specific assignments have been made to each of the committees which now will go to work to prepare reports for the September sessions of the House.

Following is a list of the committee chairmen:

Committee on Certificates of Commendation—Arnold L. Brown, M.D., Pontiac;

Committee on Constitution and Bylaws—Charles J. France, M.D., Detroit;

Committee to Study Multi-County Medical Societies—Donald D. Finlayson, M.D., Sault Ste. Marie;

Committee to Study Procedures of House of Delegates — Edwin S. Woodworth, M.D., Howell;

Committee to Select Michigan's Outstanding Physician—Conrad R. Lam, M.D., Farmington;

Committee on Reapportionment—Philip K. Stevens, M.D., Mt. Clemens;

Committee to Determine Monetary Value of Unit of Relative Value Scale—Ross V. Taylor, M.D., Jackson; and

Committee to Study Financial Structure of MSMS—James D. Fryfogle, M.D., Southfield.

FIFTH ANNUAL
MICHIGAN CONFERENCE ON MATERNAL
AND PERINATAL WELFARE
March 24-25, 1966, at Flint

Wayne State University President William Rea Keast, left, and Medical School Dean Ernest D. Gardner second from left were pleased to accept the $30,953 presented for medical school scholarships by the Wayne County Health Foundation from Donald N. Sweeny, Jr., M.D., third from left, Foundation Chairman, and from Francis P. Rhoades, M.D., member of the Foundation Board and President of Wayne County Medical Society.

Wayne Foundation Provides $30,953 for WSU Students

A new scholarship fund of $30,953 has been established for medical students at Wayne State University—thanks to the Wayne County Health Foundation and the many Wayne County families who participated in the mass oral vaccine polio immunization in 1964.

The money is the interest on the $600,000 left over after the Wayne County Medical Society paid the costs of setting up and operating the free immunization clinics, manned by volunteer doctors and nurses. More than two and one-half million people participated and many made voluntary contributions toward the cost of the vaccine.

The grants to students by WSU will be known as the Wayne County Medical Society Scholarships.

* * *

DONALD N. SWEENY, JR., M.D., president of the foundation, has explained that the criteria and rules of eligibility for selection shall be exclusively within the control of WSU, subject to five conditions:

1. Each recipient shall be a resident of Wayne County at the time the scholarship is granted.
2. Each recipient shall indicate a good faith intent to take his postgraduate medical training in Wayne County.
3. The only academic requirement for a scholarship shall be: (a) In the case of first-year students, that they fulfill the entrance requirements and enroll in the medical school, and (b) In the case of second-, third- and fourth-year students, that they be students in good standing in the medical school.
4. Financial need as usually determined shall not necessarily be a requisite for granting a scholarship.
5. The scholarships may be in the form of outright gifts or loans, in the discretion of the university.

* * *

THE WAYNE COUNTY Health Foundation was created by the medical society to determine the uses for the $600,000 fund. Four physicians and five laymen comprise the fund. The physicians are Doctor Sweeny, Chairman; Brock E. Brush, M.D., John G. Graham, Jr., M.D., an Francis P. Rhoades, M.D.

Many of the other county medic societies who experienced a surplu after the polio vaccine campaig have also established foundation and several others already have pr vided funds for scholarships.

2 State Doctors Help Write New US C-C Report

WASHINGTON, D. C.—A pan of leading businessmen has warne of the dangers of relying too heavil on government for administration c health and retirement plans.

Such government programs shoul be used to help the sick, disable and aged, the panel said, "only voluntary and private means—trul and tested—cannot adequately mee society's needs."

This statement was a highlight c a 263-page report by the Task Forc on Economic Growth and Oppo tunity, which was an independen group set up under the sponsorshi of the U.S. Chamber of Commerc The report was entitled "Povert The Sick, Disabled and Aged."

The report contains special arti cles written by F. C. Swartz, M.D Lansing, and B. C. Payne, M.D Ann Arbor. (Please see also th Viewpoint guest editorial on this re port.)

West Michigan Health Fair Set

One of the largest health fairs i Michigan is being planned by th Muskegon County Medical Societ and other area community organiza tions interested in health. The West ern Michigan Health Fair will b held at the L. C. Walker Sport Arena in Muskegon, May 2-7. grant of $4,000 from the Muskego Medical Foundation, Inc., is helpin to finance the fair. There will be n charge for exhibit space.

Leland E. Holly, III, M.D., is th general chairman.

He Who Runs May Read That...

SAGINAW — Physicians in the aginaw Valley are invited to a speal seminar on respiratory diseases ebruary 24, at the Bancroft Hotel, om 1:30 to 9 p.m.

Emphasis will be on chronic bronitis and emphysema.

Major speakers will include eorge W. Wright, M.D., Clevend; E. Osborne Coats, Jr., M.D., etroit; Joseph R. Smith, M.D., nn Arbor, and J. Irvin Nichols, xecutive Director, Michigan Tubrculosis and Respiratory Disease ssociation.

Cooperating with MTRDA in onsoring the program are the Sagaw, Midland and Bay-Arenacsco County Medical Societies.

* * *

JACKSON—The pilot project of e Michigan Plan for Hospital anagement, started a year ago to elp hospitals halt or slow down creasing costs, has been rated by ospital officials as very successful. he 29 southwestern Michigan hositals in the pilot area "are introucing changes in procedures and stems that will result in a savings f a quarter-million dollars in 1966," eclares C. G. Skinner, Jackson hosital administrator. The Michigan lan has been supported by a $96,96 grant from the W. K. Kellogg oundation.

* * *

DETROIT—Harry C. Saltzstein, .D., is the first president of the ew Detroit Cancer Club, a clinical rganization sponsored jointly by e Michigan Cancer Foundation nd the American Cancer Society. . L. Reed, M.D., is the secretary-reasurer. The meeting January 25 ealt with "Primary Therapy of arcinoma of the Breast."

* * *

HONOLULU—Speaking here to he Hawaii Medical Association in Honolulu recently was Hugh W. Brenneman, executive director of Michigan State Medical Society.

17th Cancer Day At Flint, April 6

In addition to speakers from New York and Texas, previously announced in Michigan Medicine, the Genesee County Medical Society's 17th Cancer Day Program, April 6, will offer authorities from Minnesota and Canada.

Max E. Dodds, M.D., Chairman, announces that William H. Remine, M.D., of the Mayo Clinic, will discuss "Gastric Cancer," and T. A. Watson, M.B., of the Ontario Cancer Foundation, will review "Present Status of Radiotherapy in the Treatment of Cancer."

All MSMS members are invited to the program at Hurley Hospital, Flint, from 9:30 a.m. until 5 p.m.

MSMS Elects 10 To New Judicial Commission

Balloting by MSMS members resulted in the election of the following members to the MSMS Judicial Commission:

District 1—Louis J. Bailey, M.D.; Wyman C. C. Cole, Sr., M.D.; Hugh M. Fuller, M.D., and Donald N. Sweeny, Jr., M.D. (all of Wayne County)

District 2—Harold A. Furlong, M.D., Pontiac

District 3—Norman F. Miller, M.D., Ann Arbor

District 4—H. Maxwell Golden, M.D., Flint

District 5—Sherman E. Andrews, M.D., Kalamazoo

District 6—Carl B. Beeman, M.D., Grand Rapids

District 7—Reader J. Hubbel, M.D., Traverse City

The Commission was authorized by the 1965 MSMS House of Delegates, which also set up the election procedure.

MD-DO Editorial:

(Editor's Note: The following is an editorial from the Ypsilanti Press following the hearing conducted by the State Affairs Committee of the Michigan House of Representatives on the proposed DO college.)

"Statements came out recently which we never expected to see in our lifetime. A spokesman for the Michigan State Medical Society urged at a public hearing in Detroit that 'amalgamation of the doctors of osteopathy and doctors of medicine is the road to the best health care for the people of Michigan.' At about the same time the associate dean of the University of Michigan Medical School was saying that virtually no difference exists in educational requirements in the two fields.

"For a generation, a bitter, mostly undercover, battle has flared between the two fields of medicine. As in most fights of this kind, the public has suffered most.

"Bringing the issue to a head now is a proposal to construct a $50 million college of osteopathy with state funds. Amalgamation and equal respect for the two would make this unnecessary, among other things.

"Entirely aside from the $50 million (a pretty big 'aside,' incidentally) the people of Michigan will benefit greatly from having the two fields working together instead of against each other. We hope that the recent statements are real evidence of progress ahead."

New WSU President Outlines Hopes for Medical School

In discussing his expectations for the Medical School, Wayne State University's new president, William Rea Keast, told the Wayne County Medical Society, January 10, about six expanded programs.

WSU President Keast, in his first address to the medical profession, expressed hope that the present WSU Medical School entering class of 125 can be increased to 200 or 250 within the next three or four years. Expansion, he noted, hinges upon financial support from the state and the availability of faculty.

The WSU Medical School could have 1,000 students enrolled within four, five, or six years, he predicted.

"We also look forward to more students in graduate study programs (there now are 78 working on Ph.D.'s) in the medical school," he added.

* * *

PRESIDENT KEAST outlined WSU plans to increase the training of paramedical personnel—especially in occupational therapy, medical technology, radiological technology, and physical therapy. The university, he assured, will examine its responsibilities for other kinds of paramedical assistants, and also will seek to phase them in with the community colleges.

The fourth area of expansion discussed by President Keast was that of postgraduate training for doctors now in practice.

President Keast also said that he will work for a closer relationship between the medical school and the rest of the university. "We hope to provide ways for medical education to draw from and to contribute to the other departments of the university—such as pharmacy, biology, nursing, social work, social sciences, business and law." He pointed out that it is not possible to carve up the real world into the departments as on a campus.

The sixth increase predicted by the president was for an increase in research at the medical school. He also suggested the needs for research in determining health care needs, and in meeting the new curriculum needs in the health vocations.

"Within five years or so," President Keast remarked, "the WSU medical school will be responsible for 3,000 students in various training programs—and this can be carried out only with the cooperation of the medical profession, the state legislature and the rest of the university." He appealed for goodwill, vision and patience in greater Medical School service, education and research.

The full cooperation of the medical profession was pledged to the WSU president by Wayne County Medical Society President Francis P. Rhoades, M.D., in his closing comments. The meeting was held at the WCMS headquarters, with Alfred H. Whittaker, M.D., a member of the WSU Board of Trustees, introducing President Keast.

Ambitious plans for the WSU Medical School were shared by WS
President William Rea Keast, center, before his address to the Wayn
County Medical Society meeting, with Alfred H. Whittaker, M.D., left, mem
ber of the WSU Board of Trustees, and Gordon H. Scott, Ph.D., vice pres
dent for medical school expansion.

15 Committees Busy in January

Many MSMS Committees hav held meetings already this year t advance various projects. Most these have met at the MSMS head quarters in East Lansing, with a fe others at Detroit, Ann Arbor, other communities for special rea sons.

The following information is fro the MSMS Committee record During January — Highway Acc dents Prevention, Education Liaiso Publication, Postgraduate Educa tion, Professional Insurance Plan Maternal Health, Occupation Health, Legal Affairs, Liaison wit Pharmacy, Courses on Medical Ec nomics & Ethics, Medical Care Pr grams, Judicial Commission, Com mittee on Aging, 1966 Annual Se sion Programs, and Medical Aspec of Organized Athletics.

DETROIT—During Communit Health Week, Detroit Health Com missioner John J. Hanlon, M.D made an appeal that young peopl consider careers in health. He espe cially pointed out the need in De troit now for public health nurse

TOWARD GOOD CARE AT REASONABLE COSTS

By Robert P. Gerholz, Flint
President
Chamber of Commerce of the United States

I doubt that any group is more aware and more concerned about the upwards spiral of health care costs than the medical profession.

As we know, part of the increase can be atributed to the constantly improving quality of health care. No one wants to economize here.

But much of the increase also has been attributed to unwise and excess use of our health facilities and the time of doctors and other highly paid professionals in the field.

With the advent of Medicare and the population boom, if anything, demands on health care will multiply, and an already serious problem will be aggravated.

* * *

RECENTLY A TASK FORCE on Economic Growth and Opportunity, sponsored by the National Chamber, studied the problem of health care costs as part of its work in preparing a report entitled "Poverty: The Sick, Disabled and Aged." This is a group of more than 100 men, mostly the top officers of some of the nation's argest businesses.

The Task Force worked closely with the medcal profession, including two experts at the University of Michigan. Among its recommendations were:

—The establishment of efficiency committees n every community or large hospital, composed of doctors, businessmen, industrial engineers, and other professionals, to make sure that health facilities are used as economically as compatible with good treatment.

—Community-wide coordination of all health care facilities and services, to avoid costly duplication.

—Expansion of home care, because many persons in hospitals could be treated as well at home at one quarter the average daily hospital charge of $40.

—Construction of more nursing homes and hospitals for the chronically ill, because many persons in general hospitals could be cared for as well and at considerably less expense in these facilities.

—Utilization committees of doctors in every hospital to assure that patients receive all the services they need—but no more—and are discharged promptly when ready to leave.

—Better organization of doctors' services in communities.

—Improvement of preventive health care programs.

* * *

THESE RECOMMENDATIONS if carried out throughout the nation could prove to be a great step forward toward more efficient, effective and economical health care.

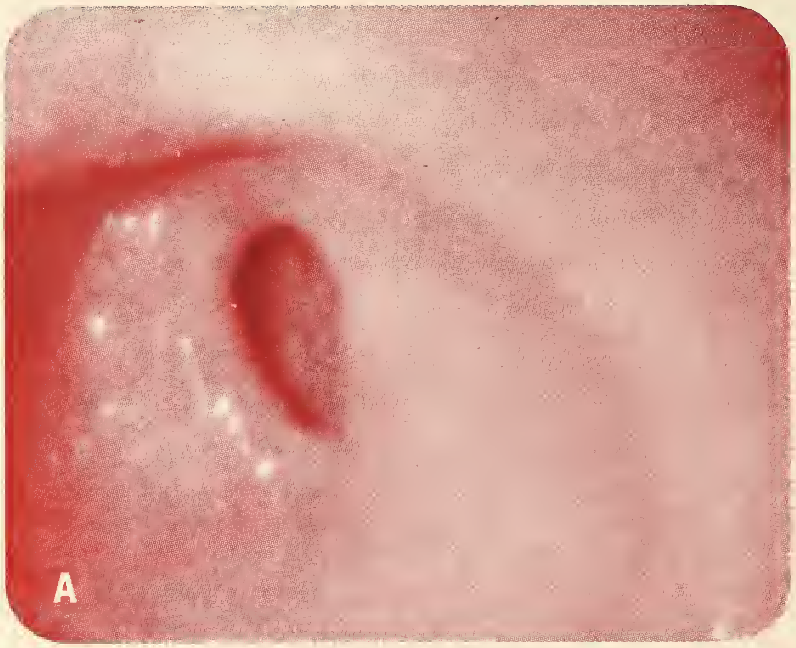
BIG SHOES TO FILL

By B. M. Harris, M.D., Chairman
Publication Committee

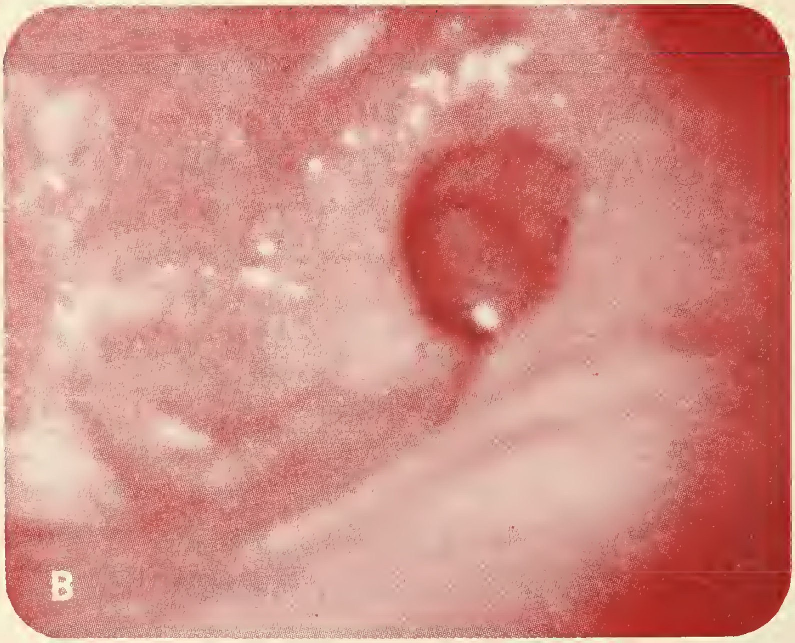
A little more than two years ago the Journal was faced with the loss of Wilfrid Haughey, M.D., Battle Creek, as editor. The history of our publication was the stewardship of Dr. Haughey, and it has been an illustrious one.

The search for a replacement was conducted under the chairmanship of the late William Scott, M.D., Kalamazoo, culminating in the selection of C. J. Tupper, M.D., Ann Arbor.

With any scientific publication the responsibility for selection and editing of material that has broad acceptability to the membership, in interest, timeliness and format, requires a considerable degree of perception. Michigan Medicine must



Which Is Pyloroplasty with Vagotomy?
Which Is Pro-Banthīne?



Photographs—Harry Barowsky, M.D., Lawrence Greene, M.D., and Robert Bennett, M.D., from a Scientific Exhibit presented at the Annual Meeting of the American College of Gastroenterology, Bar Harbour, Florida, Oct. 24-27, 1965.

Another example of
Pro-Banthīne®
(propantheline bromide)
a true anticholinergic in action

Normal relaxed pyloric antrum; contracted pylorus (pyloric fleurette)

The true anticholinergic values of Pro-Banthīne have never been so graphically realized as they are with the recent development of fibergastroscopy and the intragastric camera.

Pro-Banthīne consistently produces complete relaxation and immobility of the stomach with a dose of only 6 to 8 mg. intravenously. This is less than half the usual dose orally.

Atropine, on the other hand, required 0.8 mg. intravenously, or twice the normal dose, to achieve a similar effect. This high dose of atropine resulted in expectedly adverse side effects.

Pro-Banthīne, in minimal dosage, produces effects similar to pyloroplasty and vagotomy without the disadvantages of permanent postvagotomy sequelae.

The intragastric photograph A is of a patient who has had pyloroplasty with vagotomy. Photograph B is of a patient given 6 mg. of Pro-Banthīne.

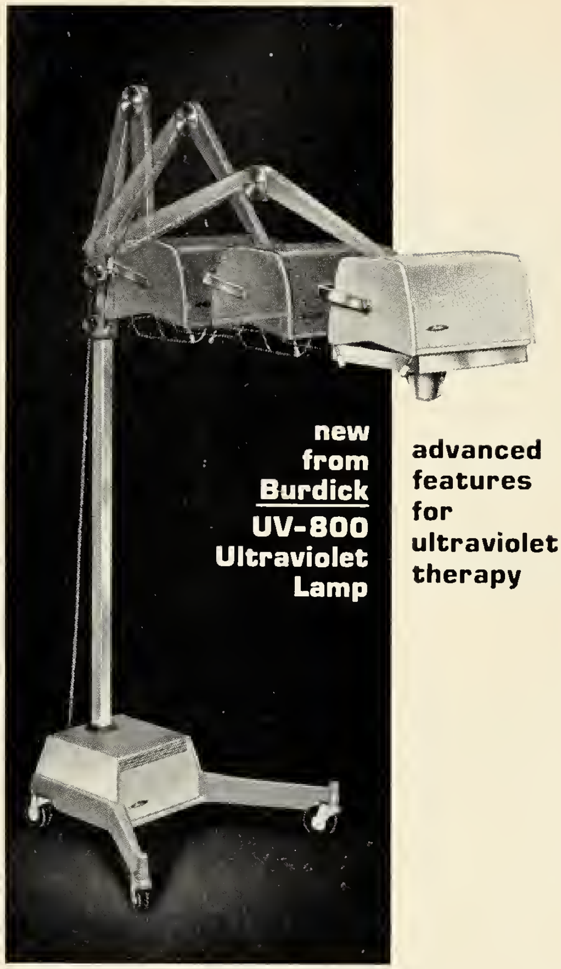
Indications: Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Oral Dosage: The maximal tolerated dosage is usually the most effective. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

Side Effects and Contraindications: Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. Pro-Banthīne is contraindicated in patients with glaucoma, severe cardiac disease and prostatic hypertrophy.

SEARLE

Research in the Service of Medicine



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VIEWPOINTS/Continued

also serve as a house organ to convey the rapidly developing concepts of our changing mores.

We feel that under the leadership of our scientific and managing editors we have accomplished in this period a great deal of progress toward these objectives. The work of Scientfic Editor C. J. Tupper and Managing Editor Herbert A. Auer has gained nationwide recognition as well as the more important approbation of our membership. It is the ambition of your MSMS Publication Committee to pursue these objectives to continue our leadership in both categories.

As you are aware, we now lose the leadership of one of the most dynamic doctors that Michigan has nurtured in the past decade. His perspicacity and gift of expression have been of invaluable service to the profession throughout our state. His Adios editorial last month is a challenge to achieve and we wish to answer with a God Speed and the sincere regret that California is about to gain so much with our loss.

URGES HIGHER MORALE

"Legislation which may infringe on the freedom of medical practice in this country must never be permitted to reduce the profession's devotion to duty.

"Regardless of our individual persuasion on matters political, regardless of any resentment we may feel either against government or our own colleagues, we cannot fulfill our obligations if we let personal feelings disunite us.

"We need unity of purpose, freedom of thought, a maintenance of curiosity. We need optimism, and a higher morale than we have needed heretofore, so that we will not be cowed into foolish and petulant action.

"We must continue to see medicine for what it is and always has been—one of the strongest and most vital gifts to mankind. You and I must provide that gift."

—James Z. Appel, M.D.,
AMA President

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An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

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(meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its antianxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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It's a friendly place Nub's Nob . . . Excellent lift facilities, snow making equipment and meticulous grooming of the slopes provide unsurpassed skiing . . . Safe, wide practice areas, expanded intermediate runs, and challenging expert slopes are the closest to mountain skiing you'll find in the midwest . . . relax in Michigan's largest heated outdoor pool, and in the evening join the congenial *apres* ski atmosphere of the Nob . . . lodging and meals . . . ski week rates . . . open winter and summer . . . Truly the top spot for friendly fun.

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VITAL ISSUES

Strengthening of the medical federation at the state and local levels is one of five vital issues facing the medical profession today, according to F. J. L. Blasingame, M.D., executive vice-president of the American Medical Association.

In a special report to the recent AMA House of Delegates, he contended that the AMA can be effective nationally only if it is effective locally.

"The state and local societies are the critical foundation of the federation . . .," he said. "The AMA can, and should, assist the state and local societies."

The other vital issues are:

- Medical education.
- Rising health care costs.
- Quality controls.
- Ethics and discipline.

OPINIONS WANTED

Remember the contaminated-tuna scare?

Remember the poisoned-cranberry scare?

Printers Ink magazine raises these questions in an editorial, while reporting that cigarette sales continue strong. The magazine suggests that some motivation research be undertaken to seek ways to discourage people from smoking.

Physicians have found that scare stories usually are a poor approach in dealing with human behavior. Warnings on cigarette packages may have a little better effect as a constant reminder.

If society is going to be successful in checking and reversing the smoking habit, we will need new and imaginative approaches.

The Forum page of the April issue of MICHIGAN MEDICINE invites your comments to the question, "How can we impress people with the dangers of cigarette smoking?"

The Pain Is Gone

Despite introduction of synthetic substitutes, efficacy of 'Empirin' Compound with Codeine remains unchallenged.

'Empirin'® Compound with Codeine Phosphate gr.1/2 No. 3

Each tablet contains: Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2½, Aspirin gr. 3½, Caffeine gr. 1/2.

Keeps the Promise of Pain Relief

BURROUGHS WELLCOME & CO. (U.S.A.) INC., TUCKAHOE, N.Y.

In Memoriam

Donovan H. Givens, M.D., Detroit

Donovan H. Givens, M.D., Detroit physician for 37 years, died December 26, 1965. He was 66.

Doctor Givens received his bachelor of science and medical degrees from Indiana University. He practiced in Chicago four years before coming to Detroit.

Among the survivors is a son, Donovan H. Givens, Jr., M.D.

J. Gregory Hamilton, M.D., Jackson

J. Gregory Hamilton, M.D., Jackson physician, died January 3 in the University Medical Center, Ann Arbor. He was 35 years old.

A native of Westport, Ontario, Doctor Hamilton was graduated from Queen's University, Ontario, in 1955. He began practice in Jackson in 1961, specializing in obstetrics and gynecology. Doctor Hamilton was affiliated with Mercy and W. A. Foote Memorial Hospitals in Jackson.

Ralph F. Kernkamp, M.D., Detroit

Ralph F. Kernkamp, M.D., 71, Detroit psychiatrist, died December 18, 1965.

Doctor Kernkamp received his medical degree from the University of Minnesota in 1923, and at the time of his death was head of the department of psychiatry at Jennings Memorial Hospital. Other hospital affiliations included Henry Ford, Detroit Memorial, St. Clair, and Doctors Hospital. Doctor Kernkamp was a member of the Michigan Society of Neurology and Psychiatry, the American Psychiatric Association, the American Association of Physicians and Surgeons and Nu Sigma Nu medical fraternity.

A past president of the Grand Traverse, Leelanau, Benzie County Medical Society, Doctor Kernkamp also served as secretary to that Society.

During World War I Doctor Kernkamp served in the Infantry and was awarded the Purple Heart.

Doctor Kernkamp was a Life Member of the Michigan State Medical Society.

Robert E. Nelson, M.D., Saginaw

Robert E. Nelson, M.D., chief of urology at Veterans Administration Hospital in Saginaw, died December 28, 1965, at Saginaw General Hospital. He was 45 years old.

Born in Brooklyn, N. Y., Doctor Nelson received his medical degree from Columbia University Medical School in 1946. Doctor Nelson moved to Saginaw in 1959 when he joined the VA Hospital.

Doctor, *DID YOU KNOW...*

that the Michigan State Medical Society sponsors the following Group Insurance Plans for its members:

Life Insurance
2 plans available including coverage for dependents

Special Accident
Death & Dismemberment up to $100,000

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Professional Overhead Expense

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Ben P. Stratton, Administrator
P.O. Box 547
Lansing, Michigan 48903

Doctor Nelson was a member of the American Urological Association, a fellow of the American College of Surgeons and was certified by the American Board of Urology. During World War II, Doctor served as an Army Medical Corps captain from 1946 to 1948.

Doctor Nelson was an associate member of MSMS.

Josef S. Rozan, M.D., Lansing

Josef S. Rozan, M.D., 61, Lansing physician and former chief-of-staff at Sparrow Hospital, died December 22, 1965.

Doctor Rozan received his master's and doctor's degrees from the University of Chicago. He served his internship at Harper Hospital in Detroit.

Active in medical and civic affairs, Doctor Rozan was a past president of the Lansing Child Guidance Clinic and Ingham County Community Service Council. Doctor Rozan was also past chairman of the board of the Rehabilitation Medical Center, a former member of the Selective Service Board and a former president of the Family Service Agency board.

Doctor Rozan was a member of the American College of Gastroenterology.

Kenneth W. Toothaker, M.D., Lansing

Kenneth W. Toothaker, M.D., Lansing physician for 32 years, died December 27. He was 59 years old.

Doctor Toothaker received his medical degree from the Wayne State University School of Medicine. He was a past president of the Ingham County Medical Society and the Michigan Academy of General Practice.

A retired commander of the U. S. Navy, Doctor Toothaker served during World War II in both the European and Pacific theaters.

Inez R. Wisdom, M.D., Ann Arbor

Inez R. Wisdom, M.D., Ann Arbor physician for more than 30 years, died December 21, 1965, in that city.

Doctor Wisdom received her medical degree from the University of Michigan in 1923. She also did graduate work there. A participating member of national and local medical organizations, Doctor Wisdom was a past president of the St. Joseph Medical Society before she moved to Ann Arbor. She was affiliated with the St. Joseph Mercy Hospital.

Doctor Wisdom was a Life Member of the Michigan State Medical Society.

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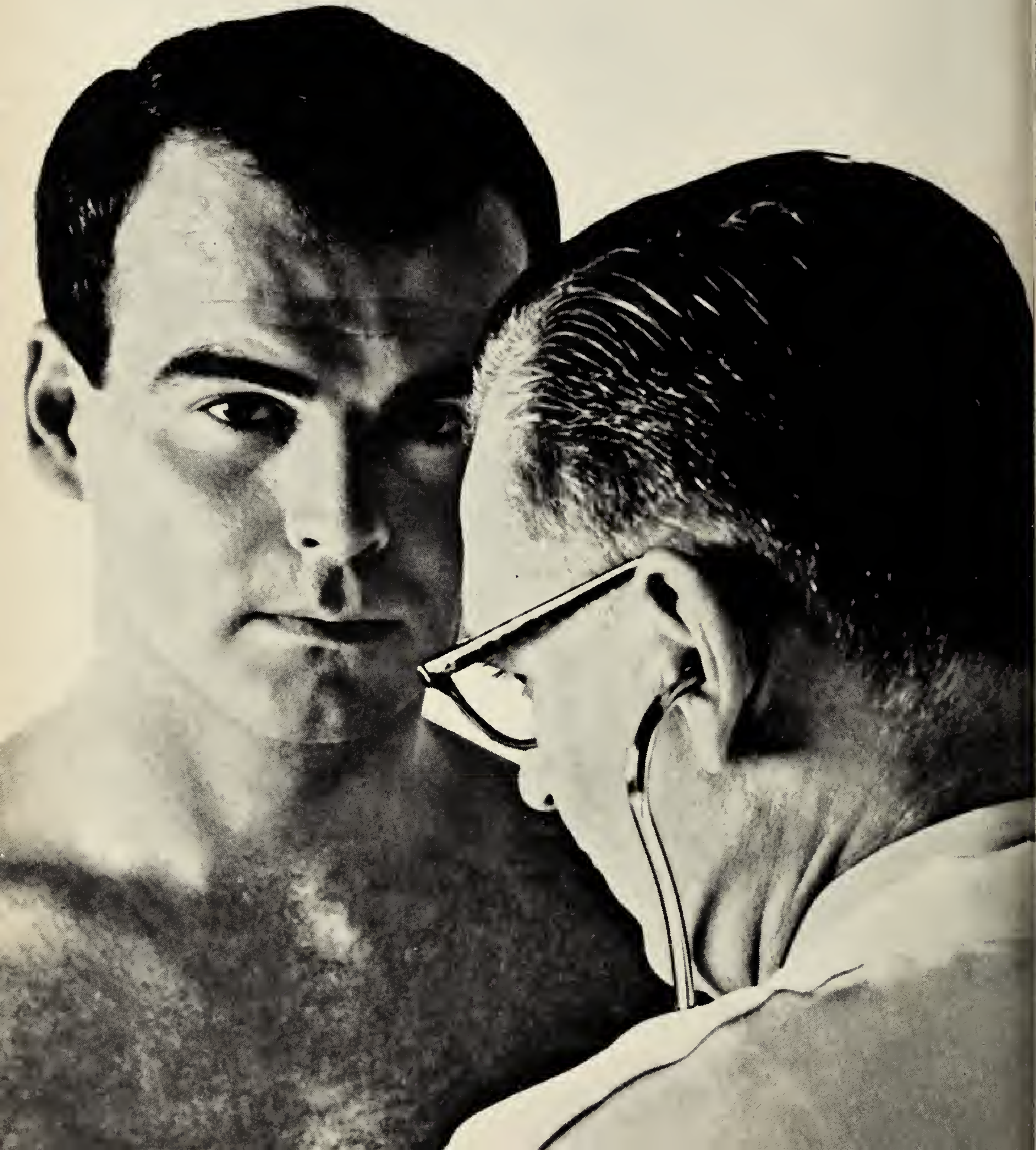

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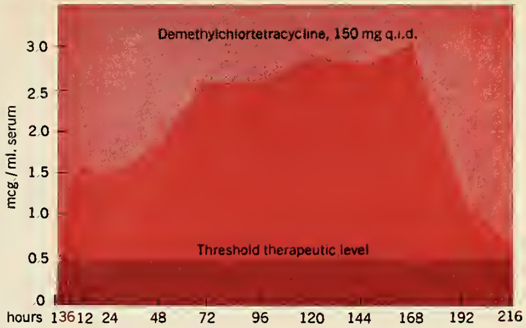
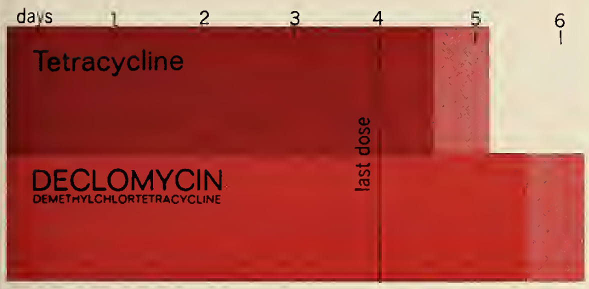


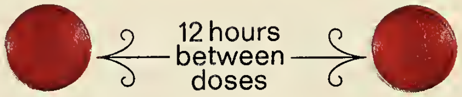
higher activity

higher activity levels with less peak-and-valley fluctuation

(Adapted from Sweeney, W. M.; Dornbush, A. C. and Hardy, S. M.: Demethylchlortetracycline and Tetracycline Compared. *Amer. J. Med. Sci.* 243:296 (Mar.) 1962.)



1-2 days "extra" activity



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Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.

Side effects typical of tetracyclines include glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis, dermatitis, overgrowth of nonsusceptible organisms, tooth discoloration (if given during tooth formation) and increased intracranial pressure (in young infants). Also, very rarely anaphylactoid reaction. Reduce dosage in impaired renal function. Because of reactions to artificial or natural sunlight (even from short exposure and at low dosage), patient should be warned to avoid direct exposure. Stop drug immediately at the first sign of adverse reaction. It should not be taken with high calcium drugs or food; and should not be taken less than one hour before, or two hours after meals.

Capsules, 150 mg and 75 mg of demethylchlortetracycline HCl.

Tablets, film coated, 300 mg and 150 mg of demethylchlortetracycline HCl.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d.

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From the Mailbag

Thank you very much for the gift copy of *A Century of Service in Medicine in Michigan* which was published in September of this year. This is indeed an excellent review of the Michigan State Medical Society, its history and dedication.

We are happy to carry an article on the book and author in the next issue of *Michigan in Books*. The material will then be added to our Michigan Collection. Thanks again and congratulations on your publication.

Sincerely,
GENEVIEVE M. CASEY, *Librarian*
Michigan State Library

I was interested in the Forum question in the January issue, about the views of younger and older doctors about social issues.

To generalize about any group is something that is foreign to most physicians. Perhaps we understand better if we say, "If the percentages are such that. . . ." With this in mind, I think that the vast majority of medical students are social conscious. They have a driving need to take care of and protect patients; this therefore, makes them want to care for the unfortunate, the down-trodden, the poor, etc. These are the people that they see the most of.

The young physicians are do-gooders, this coupled with the fact that most of their professors by natural make-up are liberals and feel the need of having a big father figure (like the federal government) to protect them. The professors instill this attitude in the students. Most medical schools' personnel feel the need of collectivism, the necessity to be a part of an organization, to be protected by the "university womb."

The fact that they get better than half of their research grants from the federal government makes them even more subservient to it. This feeling cannot help but be transferred through teaching to the student. The student being very susceptible, feels more liberally social minded.

About five years after he is out in practice and on his own as an independent, he converts to a more conservative stance. I believe his thinking has become more mature. If, however, he continues at the university, he will continue to be a liberal, social minded individual.

The contradiction that presents itself is that the young physician coming out of medical school with the above-mentioned ideas still feels that adequate

**The majority of stable adult diabetics are overweight.
The excessive body weight is accompanied by an increased, albeit delayed, release of insulin in response to hyperglycemia.
Insulin promotes lipogenesis and suppresses fat mobilization, thus favoring continued obesity in the presence of hyperglycemia and glycosuria and, at the same time, resistance to ketoacidosis.**

DBI-TD lowers blood sugar
without stimulating insulin secretion

DBI-TD lowers blood sugar
and may restore toward normal excessive insulin secreted in response to hyperglycemia

DBI-TD lowers blood sugar
without accelerating lipid synthesis and fat accumulation

come should be earned by him, and by "adequate," e means a generous income. He believes that he hould have more than adequate time off, and that e individual patient should be able to accept an-ther physician in his stead without any complaints.

I think that the older a physician becomes, the ore jealous he becomes of his ability to be able to are for a particular person. He realizes that the ore he knows about an individual patient, the bet-r he is able to care for the patient.

The young physician is interested in a mass, or a lass. The older physician takes care of one person t a time. Generalizations, as I said before, are diffi-ult.

V. V. Bass, M.D.
Saginaw

Note: Letters were sent to all the Michigan Medi-ine advertisers thanking them for their support in 965. Following is a typical reply:)

ear Dr. Leader:

Thank you for your nice letter of December 8. We ppreciate the privilege of presenting our product dvertising in MICHIGAN MEDICINE.

We are strong believers in national, state, and ounty organizations of physicians, and want to continue to support the fine work which you are doing.

Thank you so much for taking time to write to me.

EUGENE N. BEESLEY, *President*
Eli Lilly and Company

Dear Herb:

Congratulations on the 1966 look of MICHIGAN MEDICINE! It is really handsome and you've come through again with a New Look that is outstanding.

However, I would like to suggest that we run a small correction of an error that appears in the story on 14 new medical schools. The University of California, Davis, is to be a four-year medical school rather than a two-year medical school. I hope that this change may be of some interest to our readers.

C. J. TUPPER, M.D., EDITOR

(Managing Editor's Note: In the last issue of MICHIGAN MEDICINE *under the direction of Scientific Editor C. J. Tupper, an article slipped through with an error in fact—and the error concerned the new medical school at Davis, where Doctor Tupper is now the dean! The national source of the material has been informed too about the error, and we do want all MSMS members to know that the new school at Davis will be a full four-year school.)*

In the stable adult diabetic who is diet-unresponsive and overweight

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Thus DBI-TD together with proper diet usually affords effective control in the overweight, ketoacidosis-resistant diabetic ... reduces high blood sugar and elevated serum insulin levels, and leads to gradual weight loss. Anorexia has been suggested as a possible basis for weight loss; however, controlled studies suggest that it is due to the mechanism of drug action. Comparable dosages of DBI-TD do not induce weight loss or lower blood sugar in nondiabetic subjects. For the ketoacidosis-prone diabetic, insulin is still the essential hypoglycemic drug.

Now in its seventh year of clinical use... DBI-TD affords simple, convenient once-a-day or at most twice-a-day dosage for most patients.

Dosage: 1 to 3 capsules daily. **Side Effects:** Gastrointestinal, occurring more often at higher dosage levels, abate promptly upon dosage reduction or temporary withdrawal. **Precautions:** Occasionally an insulin-dependent patient will show "starvation" ketosis (acetonuria without hyperglycemia) which must be differentiated from "insulin-lack" ketosis which is accompanied by acidosis, and treated accordingly. Lactic acidosis has been reported in nondiabetics and diabetics treated with insulin, with diet, and with DBI. Question has arisen regarding possible contribution of DBI to lactic acidosis in patients with renal impairment and azotemia and also those with severe hypotension secondary to myocardial or bowel infarction. Periodic B. U. N. determinations should be made when DBI is administered in the presence of chronic renal disease. DBI should not be used when there is significant azotemia. Any cardiovascular lesion that could result in severe or sustained hypotension, which may itself lead to development of lactic acidosis, should be considered cause for immediate discontinuation of DBI at least until normal blood pressure has been restored and is maintained without vasopressors. Should lactic acidosis occur from any cause, vigorous attempts should be made to correct circulatory collapse, tissue hypoxia, and pH. **Contraindications:** Severe hepatic disease, renal disease with uremia, cardiovascular collapse. Not recommended without insulin in acute complications of diabetes (metabolic acidosis, coma, severe infections, gangrene, surgery). **Pregnancy Warning:** *During pregnancy, until safety is proved, use of DBI, like other oral hypoglycemic drugs, is to be avoided.*

Consult product brochure.

Also available: DBI tablets 25 mg.

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An antibiotic of choice is one that works

TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

The Plus... Consistent Performance

Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

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TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References** 1. Isenberg, Henry D.: Health Laboratory Science **2**:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine **70**:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science **1**:185-256 (July-Aug.) 1964.

MSMS Offers Group nsurance Benefits

It is well known that the Michigan State Medical ciety sponsors several insurance plans for the bene- of its members.

Because many members are not certain as to what ans are available it seems worthwhile to outline e MSMS Insurance Program and to at least briefly scribe each plan.

HOSPITAL—SURGICAL—MEDICAL

This is the familiar Blue Cross-Blue Shield Plan d it is available to all members and their depend- ts.

Details as to benefits and enrollment are probably ready known to you but you may obtain further formation from the MSMS office.

LONG TERM DISABILITY

This is often referred to as the most basic type of surance protection because it insures your most val- ble economic asset—your earning power.

Provident Life and Accident Insurance Company the carrier and a variety of plans and amounts e available.

A popular plan provides benefits of $500 monthly to lifetime for accident and to age 65 for illness.

Lesser amounts are available as well as alternate riods of indemnity.

A unique feature is the partial disability benefit yable for illness as well as accident.

Policies may be continued to age 75.

LIFE INSURANCE

The MSMS Group Term Life Insurance Plan was signed to provide basic protection at very low cost. fter one year it may be converted to Group Perma- nt which offers the advantages of level premium d level face amount and increasing cash and paid values. The maximum amount available is 0,000.

The carrier is Mutual Benefit Life Insurance Com- ny of Newark, New Jersey, one of America's oldest d largest life insurors.

Also available is a Family Plan which was offered augment the limited amount available in the basic an and to provide coverage for spouse and unmar- d children.

Amounts of insurance of $10,000, $20,000, and 0,000 are available with $5,000 coverage for spouse d each child over six months of age. The insurance provided is of the term style for maximum protection at the lowest premium.

Continental Assurance Company of Chicago is the carrier for the Family Plan. This Company too is a leader in its field and is one of America's largest group writing carriers.

PROFESSIONAL OVERHEAD EXPENSE

The newest plan of insurance is one designed to reimburse you for the expense of maintaining your office during periods of disability.

Premiums paid for this type of insurance constitute business expense and are deductible for tax purposes.

Amounts up to $1,500 monthly are available and benefits for total disability are payable up to 24 months.

SPECIAL ACCIDENT INSURANCE

This is a special form of insurance to provide substantial benefits for loss of life, limbs or sight as the result of accidental bodily injury.

Amounts up to $100,000 are available and your wife may be included for 50% of the amount applying to you.

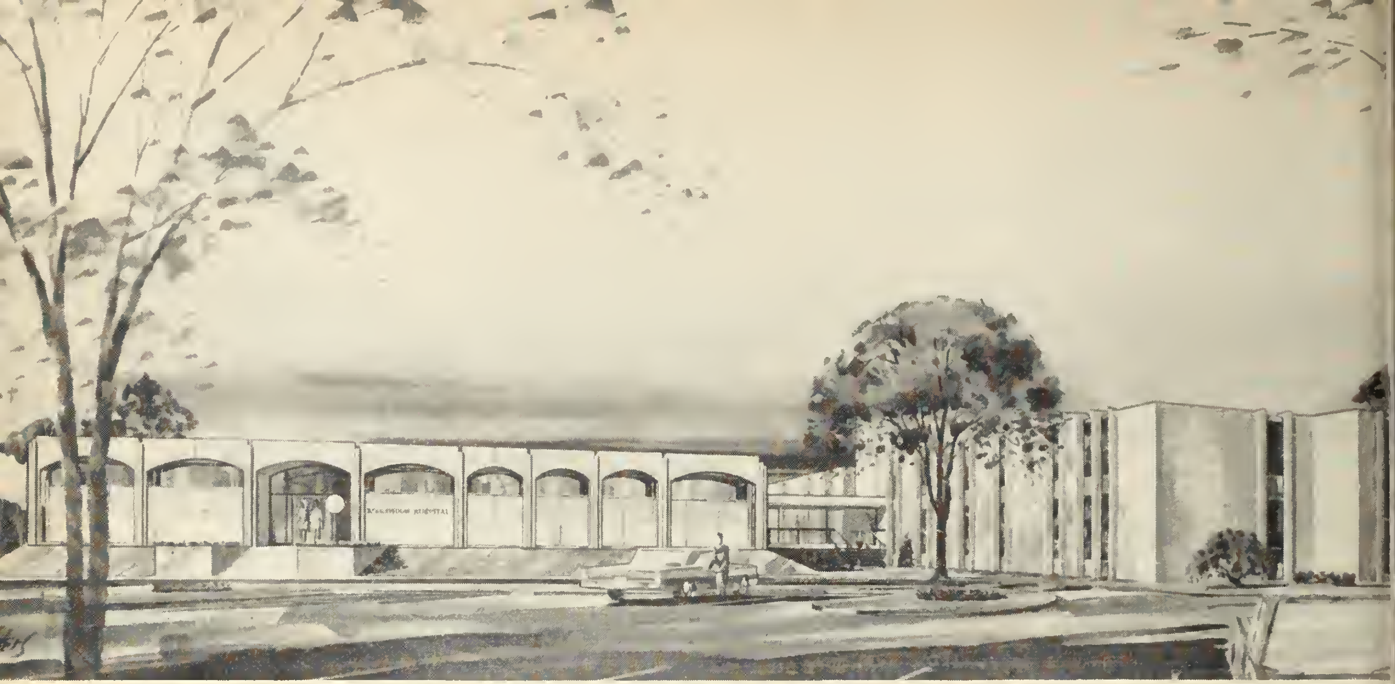
This is around-the-clock protection and the premium cost is low. As an example the annual premium for $100,000 protection is only $72.00.

Sees Insurance Firms Supplementing Medicare

Speaking at a Medicare workshop at the Health Insurance Association of America's Individual Insurance Forum in Minneapolis, Arthur E. Hess, Director, Bureau of Health Insurance, Social Security Administration, said that the opportunity for health insurance companies to write coverages supplementary to Medicare is "significant."

Opportunities, he said, lie in the area of deductibles, co-insurance, and excluded items and services, particularly drugs. He noted that the coverage under Medicare is limited "to perhaps a little less than half of the total health care costs of the aged."

He told the insurance men that the "partnership" between the government and the health insurance business—"whether we think of it as a shotgun wedding or what" — has tremendous potential.



KINGSWOOD HOSPITAL OPENS
the first of an eight-unit complex

Michigan's finest and newest facility for acute treatment of voluntary, neuropsychiatric patients, Kingswood Hospital, consisting of a 100-bed nursing wing and adjoining administration and therapy building, will be prepared to accept patients by February 15, 1966.

Founded to help fill the growing need for short term, intensive care in the mental health field, Kingswood Hospital is the only private hospital in the metropolitan Detroit area originally constructed for that purpose. It is located in northwest Detroit and southern Oakland County on Eight Mile Road, between Wyoming and Meyers Roads.

Only ambulatory patients can be admitted either by referral to a private psychiatrist on the Kingswood Staff, or through arrangements made by the hospital's Medical Director. The following programs are available:

. . . In-patient care
. . . Day-Care and Night-Care
. . . Occupational and Recreational Therapy
. . . Studio-type accommodations
. . . Full range of professional psychiatric services

Philip N. Brown, M.D.
Medical Director

Marvin J. Lawrence, F.A.C.H.A.
Administrator

KINGSWOOD HOSPITAL
10300 W. EIGHT MILE ROAD
FERNDALE, MICHIGAN Telephone: Area 313 398-3200

SPENDING HABITS OF AFFLUENT SOCIETY:

As a result of a massive study of demand for 700 roducts and services, sponsored by LIFE magazine nd conducted by the Bureau of Labor Statistics, the ational Industrial Conference Board has drawn up "road map" to the spending habits of the affluent ociety.

Some Highlights:

Twenty-five per cent of income against 30 per ent at the start of the last decade is being spent for ood.

Tobacco and alcohol each get about 2 per cent f the budget. (Interestingly, families in the $10,000-nd-over group spend substantially more for booze han for tobacco, but the situation is just the opposite the lower-income group.)

Expenditures for furniture, appliances and related ems are getting slightly less. About 5 per cent down om the Fifties, which, to add perspective, was a eriod of pent-up demand.

The home now gets nearly 30 per cent of the pical family budget. (Says the NICB: "This steep se in spending for shelter, spurred by the move to e suburbs, reflects the overall improvement in the ountry's living conditions.")

Clothing and shoes take about 10 per cent of the amily budget, somewhat less than a decade ago. Not surprising: The woman spends one-third more han the man for clothing.)

Medical care and personal care expenditures are n the upswing — 8 per cent to 9 per cent in the ast decade. Behind the rise in medical expenditures: ew medical and hospitalization programs and in-reased longevity, says the NICB.

Fifteen per cent of the average family budget is pent on transportation. Most of this spending goes r the purchase, maintenance and operation of the amily car. That, says the study, "is up considerably" ver a decade ago.

Real family spending is up 15 per cent, which, ombined with population growth, has resulted in a 0 per cent rise in real consumer demand.

Conclusion: The steadily growing affluence of the merican family is supplying considerable thrust to e American economy. Look for continued pros-erity.

Materials for the Medical Socio-Economic Section of MICHIGAN MEDICINE are provided by Richard M. Campau, MSMS Research Director.

The most significant advance in analgesics since the isolation of morphine in 1805

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BRAND OF OXYMORPHONE, ENDO

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clinically tested for 5 years/evaluated in 120 U. S. hospitals/over a quarter of a million doses given/more than 25,000 patients treated

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Vials: 10 cc., singly and in boxes of three.
Ampuls: 1 cc. and 2 cc., in boxes of 12 and 100.
(Each cc. of NUMORPHAN* contains 1.5 mg. oxymorphone as the hydrochloride.)
Suppositories: 2 mg. and 5 mg., in boxes of 6.

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Varied Activities Serve the Public

Mason County Medical Society members provided free urinalyses in their office for a county-wide diabetes detection effort. The service was also provided at the Paulina Stearns Hospital at Ludington.

Members of the City Commission, civil defense officials and Red Cross representatives were special guests at the **Kalamazoo Academy of Medicine** meeting which dealt with the management of mass casualties. Col. Howard G. Krieger, chief of the Fifth Army Surgeons' Office Professional Services Branch, spoke.

Lenawee County Medical Society during January conducted a tetanus immunization project, with the second shots this month and the third planned at the county fair in August.

The Lenawee doctors recently toured the new Fisher Body plant at Tecumseh to see the plant hospital and to learn about the industrial health program there.

Oakland County Medical Society is the only one in Michigan listed among the current sustaining members of the Student American Medical Association. The "Honor Roll" appears in the December issue of "The New Physician." MSMS and other county medical societies make contributions to the two Michigan chapters of SAMA and are not national sustaining members.

Calhoun County Medical Society Foundation, Inc., will be headed by D. L. Finch, M.D., Battle Creek, as the first president. Nine community leaders and physicians have been appointed to the board and bylaws have been adopted. **The Calhoun County Medical Society,** the moving force behind the fund which has $40,000 from the polio clinic excess, proposes grants and loans to students training for ancillary medical services.

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And this service begins by informing your patients about the American Health Credit Card, which permits them to pay you immediately for the health and medical services you perform.

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A.H.C.P. and the U.S. Mail will do the rest.

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She's discouraged.
She needs your help.

You can encourage her with DEXAMYL®
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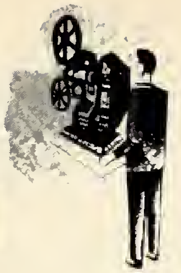
'Dexamyl' is the mood-lifting anorectic; it not only assures unexcelled control of appetite but also improves outlook.

Formula: Each 'Dexamyl' Spansule® (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming]. *Principal cautions and side effects:* Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild. *Before prescribing, see SK&F product Prescribing Information. Smith Kline & French Laboratories, Philadelphia* SK&F

ANCILLARY ACTIVITIES



Discusses Future Of Mental Health Clinics in State

By Philip B. Smith, M.D., Assistant Director
State Department of Mental Health
Community Services Division

At present the Department of Mental Health operates child guidance clinics, adult mental health clinics and combined all-purpose mental health clinics, providing access to clinic service in all parts of Michigan. Characteristically each clinic is incorporated as a non-profit corporation with its own local advisory board.

Most of the professional personnel of the local clinics are State Civil Service employees; however, some professional personnel, some consultants and all of the nonprofessional personnel are employees of the local clinic but are not state employees. Some clinics own their physical facilities, and some rent or lease them. The state does not own, provide or contribute to the maintenance of any of those clinic physical facilities.

Public Act 54 (section 330.609) states, "In counties where community mental health service programs are established pursuant to this act, all existing—clinics—under the administration of the Department of Mental Health and—financed in part by State funds shall—(a) (become) administered by existing local clinic boards and, (b) (become) approved for contractual services by the community mental health service board, within five years after the effective date (Sept. 6, 1963) of this act."

It appears, at this time, that there are three possible results to obtain:

Option I

The now "advisory" clinic board may modify its articles of incorporation to provide that it become an "administrative" board and set up a local administrative structure for the clinic, *simultaneously:*

A. Taking over the administrative control of the clinic which is now exercised by the Department of Mental Health, and thus succeeding the authority of the state and relinquishing direct financial support from the department, and

B. Establishing, through contracts for services with local community mental health service board(s), new source of assumed financial support.

Option II

The now "advisory" clinic board may choose dissolve and request that a local community ment health service board assume administrative authori for operation of the clinic as a direct service oper tion.

Note: In either of these two options, no provisi is made for services to all of the several counti which may constitute an entire area now bei served by a shared state clinic. Those counties whi have clinics or clinic systems whose service area limited to a single county (Oakland, Macomb ar Wayne) are not so affected. Act 54 as it now stan does not jeopardize services to such counties. Ho ever, 17 other counties (Marquette, Emmet, Alpen Grand Traverse, Isabella, Bay, Saginaw, Muskego Kent, Genesee, St. Clair, Ingham, Berrien, Kalam zoo, Calhoun, Jackson and Washtenaw) could l gally absorb all of the state clinic services within the county mental health services board structure witho being required to provide service to residents other counties. Thus as the act is written, 63 Mich gan counties have no *guarantee* of continued servi upon which they have heretofore had reliable acce

Option III

During the five-year period beyond the effecti date of Act 54 (Sept. 6, 1963) the state clinics ca continue to operate as they are now constituted, a tempting to coordinate their services with local ser ices provided by local community mental healt service boards, contracting their service in part local mental health service boards as appropriate an continuing to provide services to their entire servi area, while planning ultimately to choose Option or II as presented above.

Act 54 allows the formation of multi-county ment health service boards, and does not prevent counti from contracting for mental health services fro neighboring counties; the act does not state a po sible alternative if a single county containing a existing clinic chooses to develop its services for itse and remain independent from its neighbors. Th operational autonomy can seriously jeopardize t services to any county not now having an existi State-local clinic of its own.

Counties with small but fairly equal populatio may profitably join together to effect a mutual shared service program which will, nevertheless, limited in scope because of its limited financial ar incompletely comprehensive service base. Small (population) counties adjacent to heavily populate counties have little possibility of assuring themselv guaranteed adequate access to comprehensive ment health services without inordinate cost and unfor seeable good fortune in obtaining necessary profe sional manpower.

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pargyline hydrochloride 25 mg. and methyclothiazide 5 mg.

for control of
moderate to severe
hypertension

Unique combination produces greater antihypertensive effect with lower doses

Eutron is the combination in a single tablet of 25 mg. Eutonyl (pargyline hydrochloride) and 5 mg. Enduron (methyclothiazide). This combination produces greater therapeutic effect than that of either component used alone. Side effects may be milder, too, as dosages are generally lower. The effective dosage is usually one tablet, once daily. Tablets are scored for greater dosage flexibility.

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ENDURON™
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Each Eutron tablet contains two proven antihypertensives in the ratio shown to be most effective in most patients.

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New **EUTRON** extends your range of treatment in moderate to severe hypertension

A single product you can use even in the presence of congestive heart failure or edema

Eight out of 10 patients respond

In clinical trials, Eutron produced normotension or a significant reduction in blood pressure in eight out of 10 patients studied. The rationale for the product is this: Eutonyl used alone is a potent antihypertensive. Its antihypertensive action is markedly enhanced by Enduron, a potassium-sparing thiazide.[1,2,3] The combination (Eutron) thus produces greater antihypertensive effect with lower dosages of the Eutonyl component, and milder side effects may be seen.

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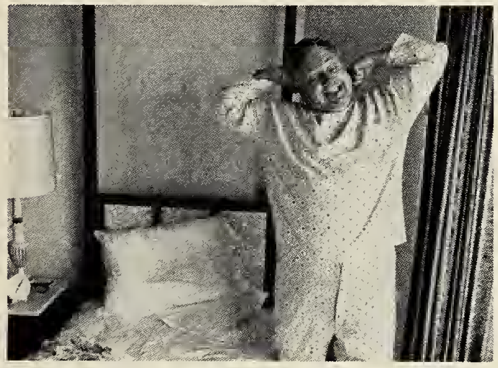
1. Torosdag, S., Schvartz, N., Fletcher, L., Fertig, H., Schwartz, M. S., Quan, R. F. B., and Bryant, J. M., Pargyline Hydrochloride as an Antihypertensive Agent With and Without A Thiazide, Am. J. Cardiol., 12:822, Dec., 1963.
2. Pollack, P. J., Pargyline Hydrochloride and Methyclothiazide Combined In The Treatment of Hypertension, Cur. Thera. Res., 7:10, Jan., 1965.
3. Bryant, J. M. et al., Antihypertensive Properties of Pargyline Hydrochloride, New Non-Hydrazine Monoamine Oxidase Inhibitor Compared with Sulphonamide Diuretics, J.A.M.A., 178; 406, Oct., 1961.

BP reductions in the recumbent and sitting positions often are nearly as great as in the standing. In clinical trials, the average *recumbent* BP reduction was 36/18 mm. Hg.



The average *standing* reduction in clinical trials was 45/22 mm. Hg. Thus the difference between the standing and recumbent readings was only 9/4 mm. Hg.

Significantly lowers blood pressure in all body positions; less likelihood of orthostatic hypotension

In clinical trials, the average reduction in standing blood pressure was 45/22 mm. Hg.; in the sitting position it was 48/20 mm. Hg.; and in the recumbent position, 36/18 mm. Hg.

Because Eutron effectively reduces blood pressure in all body positions, there is reduced likelihood of orthostatic symptoms or hypotension.

This was reflected in the relatively mild character of side effects seen in clinical trials (see below).

Smooth and gradual onset

Onset of antihypertensive action is usually quite smooth. Initial reduction of systolic and diastolic readings is usually seen within a week – maximum reduction in seven to ten days.

Less troublesome side effects may be seen; frequent improvement in "sense of well-being"

Fewer than 1% of patients studied discontinued Eutron therapy because of side effects. This is due in part to the relatively low dosage needed with the combination. Usual recommended dose is one tablet daily—that is, 25 mg. Eutonyl with 5 mg. Enduron. *This is about half the usual therapeutic dose of Eutonyl given alone.* As a consequence side effects may be milder. And, as with Eutonyl given alone, the patient may well note an increased sense of well being. This is in distinct contrast to most other antihypertensive therapy.

ABBOTT

Prescribing information for **EUTRON**

INDICATIONS: Eutron (pargyline hydrochloride and methyclothiazide) is indicated in the treatment of patients with moderate to severe hypertension, especially those with severe diastolic hypertension. It is not recommended for use in patients with mild or labile hypertension amenable to therapy with sedatives and/or thiazide diuretics alone.

CONTRAINDICATIONS: Eutron is contraindicated in patients with pheochromocytoma, advanced renal disease, paranoid schizophrenia and hyperthyroidism. Until further experience is gained it cannot be recommended for use in patients with malignant hypertension, children (under 12 years of age), or pregnant patients.

The concomitant use of the following is contraindicated: other monoamine oxidase inhibitors; parenteral forms of reserpine or guanethidine; sympathomimetic drugs; foods high in tyramine such as cheese; imipramine and amitriptyline, or similar antidepressants; methyldopa. A drug-free interval of two weeks should separate therapy and use of these agents.

WARNINGS: Pargyline hydrochloride is a monoamine oxidase inhibitor. Patients should be warned against eating cheese, and using alcohol, proprietary drugs or other medication without the knowledge of the physician. When it is necessary to administer alcohol, narcotics (notably meperidine), antihistamines, anesthetics, barbiturates and other hypnotics, sedatives, tranquilizers, or caffeine, these agents can be used cautiously at a dosage of ¼ to ⅕ the usual amount. Avoid parenteral administration where possible. Withdraw pargyline two weeks before elective surgery.

Patients should be warned about the possibility of postural orthostatic hypotension. Those with angina or other evidence of coronary disease should not increase physical activity. Pargyline may lower blood sugar. Potassium depletion is unlikely at the recommended dosage, but if it occurs, adjust dosage or withdraw or provide added natural food sources of potassium; potassium tablets should be avoided wherever possible, as bleeding or obstructive ulceration of the small bowel has been associated with their use; potassium levels should be especially watched if the patient is on digitalis or steroids, or if hepatic coma is impending.

PRECAUTIONS: When determining the antihypertensive effect of Eutron, blood pressure should be measured while the patient is *standing*. Use with caution in hyperactive or hyperexcitable persons. Such persons may show increased restlessness and agitation. Withdraw drug during acute febrile illness. Watch patients with impaired renal function for increasing drug effects or elevation of BUN and other evidence of progressive renal failure; withdraw drug if such alterations persist and progress. Pargyline has not been shown to cause damage to body organs or systems. As with all new drugs, complete blood counts, urinalyses, and liver function tests should be performed periodically. The drug should be used with caution in patients with liver dysfunction. With prolonged therapy, examine patients for change in color perception, visual fields, and fundi.

Elevated blood urea nitrogen, serum uric acid or blood sugar are possibilities attributable to the methyclothiazide in Eutron. Methyclothiazide may also reduce arterial response to pressor amines. Blood dyscrasias, including thrombocytopemia with purpura, agranulocytosis and aplastic anemia, have been seen with thiazide drugs.

SIDE EFFECTS: The use of pargyline may be associated with orthostatic hypotension. Mild constipation, slight edema, dry mouth, sweating, increased appetite, arthralgia, nausea and vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, and purpura have been encountered with pargyline. Hyperexcitability, increased neuromuscular activity (muscle twitching) and other extra-pyramidal symptoms have been reported. Drug fever is extremely rare. Congestive heart failure has been reported in a few patients with reduced cardiac reserve. Nocturia has been observed with the combination. If side effects persist, despite symptomatic therapy or reduction of the dose, discontinue the drug.

ABBOTT

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tetler Heads PMA; mith Joins Parke, Davis

The Board of Directors of the Pharmaceutical nufacturers Association has elected C. Joseph Stet- of Washington as president of the association which resents 140 companies who produce more than per cent of the nation's prescription drugs.

Mr. Stetler was the speaker at the "Medicine and siness, Industry and Communications Day" lunch- during the MSMS Centennial in Detroit.

At the same time, the Board accepted the resigna- n of PMA President Austin Smith, M.D., and the ard of Directors of Parke, Davis & Company an- nced it had elected Doctor Smith as vice chair- n and to the membership of its Executive Com- tee.

Mr. Stetler, former general counsel of the AMA d director of its legal and socio-economic division, ned PMA in 1963.

Doctor Smith, before joining PMA in 1959, had n editor of JAMA.

usy AHA Leaders

Several Michigan physicians are serving on the ious councils and committees of the American Hos- al Association this year.

They include James T. Howell, M.D., Henry Ford spital, Detroit, General Council, and also a rep- entative to the Joint Standards Committee of the erican Association for Maternal and Child Health; win L. Harmon, M.D., Michigan Hospital Service, troit Committee on Home and Ambulatory Care; eph N. Schaeffer, M.D., Rehabilitation Institute Detroit on the Liaison Committee with the Ameri- Academy of Physical Medicine and Rehabilita- n, and also a representative to the American Regis- of Physical Therapists Advisory Board; and Robin Buerki, M.D., Henry Ford Hospital, Detroit, rep- entative to the Advisory Board for Medical Special- .

ore MD Placements

Recent placements by the M.D. Placement Service e included the following: Boris Kreel, M.D. rand Blanc); Boleslaw Krawczyk, M.D. (Fenn- e); Emilio Pena, M.D. (Dundee); William G. nto, M.D. (Goodrich); Larry Ellis, M.D. (Posen); d Bernard McQuillan, M.D. (Jackson).

Kingswood Hospital Ready for Patients

Kingswood Hospital, a 100-bed adult psychiatric unit, dedicated January 30, is scheduled to receive patients on February 15.

The hospital is the first of an eight-unit complex, located in northwest Detroit on Eight Mile Road between Meyers and Wyoming. Under construction since March, 1965, Kingswood Hospital is the only private hospital to be built exclusively in metropolitan Detroit for the care of acute, voluntary neuropsychiatric patients.

Philip N. Brown, M.D., former medical superintendent of Northville State Hospital, is the Medical Director of the new Kingswood Hospital.

The projected Kingswood Hospital Complex includes an additional 50-bed nursing wing, a 50-bed children's unit, a 150-bed convalescent home, a recreational center, a maintenance building and professional building.

The architects are Volk & London, and the contractor is Harry Shefman, Inc. Financing is underwritten by the Detroit Bank & Trust.

Discusses New Union Mental Health Benefits

Theodore Goldberg, Program Consultant for the International UAW-CIO Social Security Department, estimates that 35 to 45 per cent of the 2½ million persons eligible for mental health treatment in the new union program set up for industrial workers and their families, are in the Michigan area.

This first-time program of short-term psychotherapy care is the result of long study of automobile worker mental health needs and the recent UAW-CIO mental health contract clause.

To become effective on September 1, the program will provide an extension of in-hospital days from the present 30 to 45 days; out-patient service, overall maximum annual payment per person per year of $400 and payment to members of the patient's family for counseling. Payments to physicians and professional staff are similar to present insurance plans.

The program has been worked out with Blue Cross-Blue Shield. Part of the cost is to be paid by patient payments, Mr. Goldberg said. There will be no patient payment for the first five visits for professional care; a rate of 15 per cent for the second five visits; a rate of 30 per cent for the third five visits; and thereafter, a rate of 45 per cent. Mr. Goldberg could not say what the cost to industry will be, but he praised the automobile companies, as well as the professional psychiatric and psychological associations for their cooperation.

Authorities Coming For Heart Program

Doctor Zoll

Doctor Harvey

Themes to be featured at the Michigan Heart Association Annual Meeting and Scientific Sessions, February 25-26, at the Sheraton-Cadillac Hotel, Detroit, are . . .

(1) "The Use of Electricity in Heart Therapy" and "Surgically Remediable Acquired Heart Disease" at the Scientific Sessions all day Saturday, February 26. This program carries five credit hours by the American Academy of General Practice.

(2) "The Coronary Care Unit" at 1:00 p.m., Friday, February 25, with panelists, Lawrence E. Meltzer, M.D. and Miss Rose Pinneo, R.N., both of Presbyterian Hospital, Philadelphia; Clarence A. Imboden, M.D., Deputy Chief, Heart Disease Control Program, U.S.P.H.S., Washington, D. C.; and E. W. Reynolds, Jr., M.D., Heart Station, University of Michigan.

The moderator will be Jack M. Kaufman, M.D., Huntington Woods.

Speakers at the Scientific Sessions will be: W. Proctor Harvey, M.D., Chief of Cardiology, Georgetown University, "The Role of Ausculation in the Assessment of Acquired Valvular Disease"; Paul M. Zoll, M.D., Boston, "The Electrical Control of Heart Beat"; William M. Chardack, M.D., State University of New York, "Pacemakers and Their Problems"; Dwight C. McGoon, M.D., Mayo Clinic, "Experience in the Surgical Treatment of Acquired Aortic Valve Disease"; Herbert E. Griswold, M.D., University of Oregon, "The Internist's Role in Heart Valve Prosthesis"; and Donald B. Effler, M.D., Cleveland Clinic, "Surgical Treatment of Coronary Arte Disease."

There will be two panel discussions. One w feature "Treatment of Heart Block," with Joe Morris, M.D., Ann Arbor; Rodman Taber, M.D Detroit, and Doctors Chardack and Zoll. The mode ator is Richard D. Judge, M.D., Ann Arbor. Th second panel discussion will be a Grand Surgic Summary with Conrad R. Lam, M.D., Detroit, moderator, and Doctors Harvey, Griswold, McGoo and Effler.

Cancer Foundation Re-Elects Officers

Brock E. Brush, M.D., Detroit, will continue for an other term as president of the Michigan Cancer Foun dation. The annual meeting also saw the re-electio of James C. Cook, M.D., Detroit, as vice-presiden and Gerald S. Wilson, M.D., Detroit, as secretar

Physician elected now to the board was T. Evans, M.D.; and re-elected were William Bromm M.D., and Michael Brennan, M.D., all of Detroit.

Workshop Conducted For MSMAS Leaders

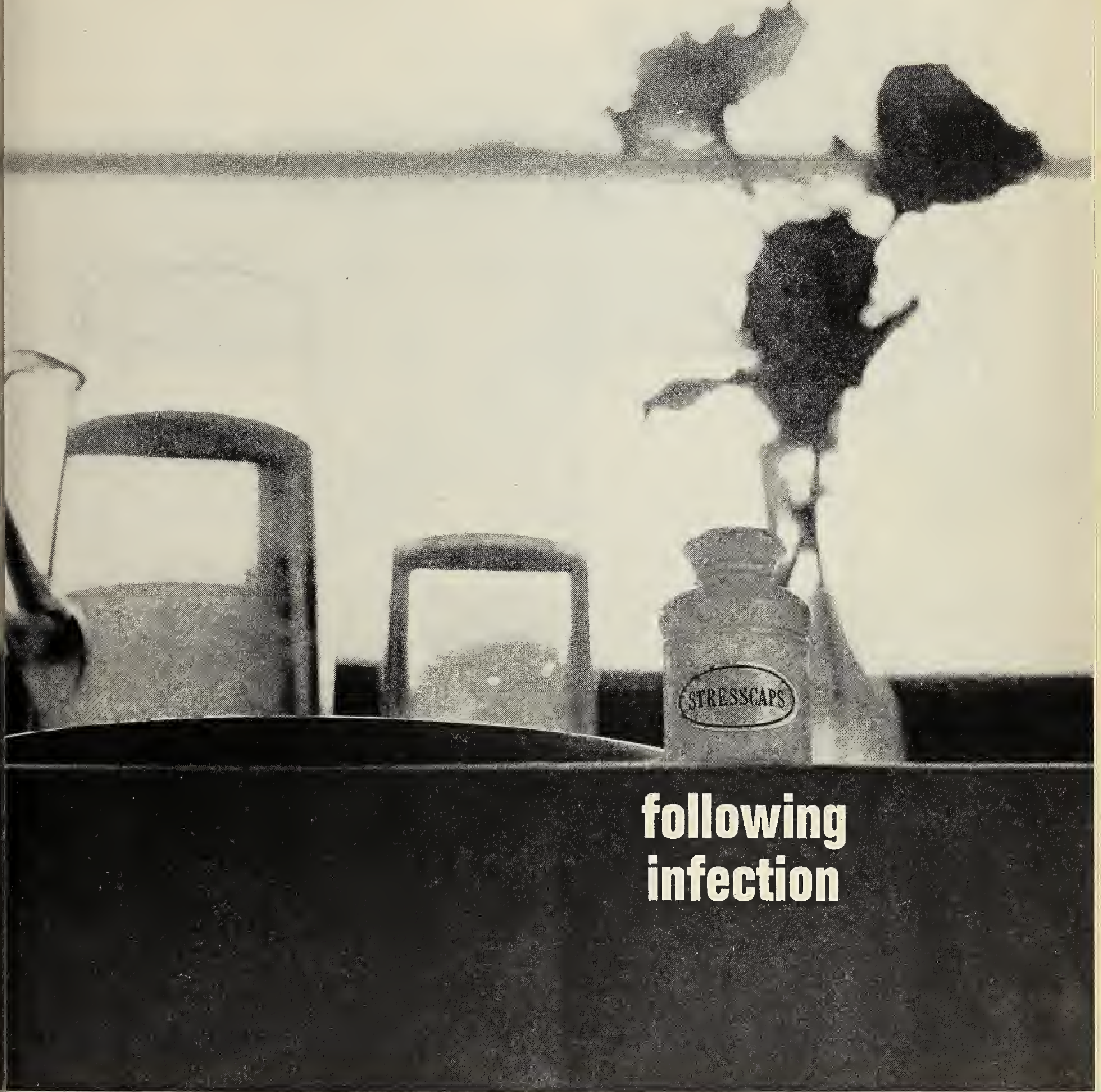
The Michigan State Medical Assistants Society he its Annual County Officers and Committee Chairme Conference in Kalamazoo with Mrs. Louise Harp as chairman. The theme was "Opportunities — R sponsibilities."

The members were welcomed by Michigan Sta Medical Assistants Society President, Mrs. Juani Ferman, and by the Kalamazoo County Medical A sistant Society president, Mrs. Jean Shaffer. Th morning was devoted to a panel discussion of leade ship skills with the members taking a very acti part. Mrs. Betty Lou Willey was the moderato Miss Phyllis Marquardt gave a resumé of the acti ities of the recent AAMA Convention in New Yor

The afternoon program included Raymond Hightower, Mayor of Kalamazoo; Glenn S. Alle Comptroller State of Michigan, and a movie abo Major Edward White's historic walk in space.

Names Russel Lecturer

James V. Neel, M.D., chairman of the Departme of Human Genetics, will deliver the Henry Russ Lecture, the highest honor The University of Mich igan can bestow on a senior faculty member, We nesday, April 13, in the Clements Library. Th lectureship, in recognition of outstanding academ and research competence, was established in 1920 an carries a $1,250 honorarium.



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Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
Vitamin B_2 (Riboflavin)	10 mg.
Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 (one month's supply) and 100 (three months' supply).

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8693-4

Next Sinai Speaker

The speaker in the Wednesday Evening Rotating Lecture Series of the Department of Psychiatry, Sinai Hospital of Detroit, February 2-9-16-23, will be Richard Sterba, M.D., psychoanalyst, lecturer and author. Dr. Sterba will present four lectures at 7:30 p.m. on 4-south on "Ego Psychology."

Sees Data Processing As Tool; Describes Washtenaw Project

Data processing as a "tool" in the control of tuberculosis is being used in a pilot study in Washtenaw County, reported N. Conant Webb, Jr., M.D., of the New Jersey College of Medicine during the 1965 Brooks Baker Lecture at the University of Michigan.

Speaking on data processing, Dr. Webb noted the expanded use of this equipment in recent years in the health field and that data processing could be most helpful in building a national case register of all persons with tuberculosis and in controlling the spread of tuberculosis. He indicated that the Washtenaw County pilot study, under the direction of Otto K. Engelke, M.D., County Health Officer, could serve as the model for such a national register service center. Patients involved in the study are listed by social security numbers with pertinent data relating to active or inactive status, treatments, and visit schedules. He indicated that a good-sized data processing center could provide data service for the entire country.

Begin Hennes Fund

An Allen R. Hennes Memorial Fund has been established at the Wayne State University School of Medicine to honor Doctor Hennes who died of a heart attack on November 22. A full professor, his special field was endocrine and metabolic diseases.

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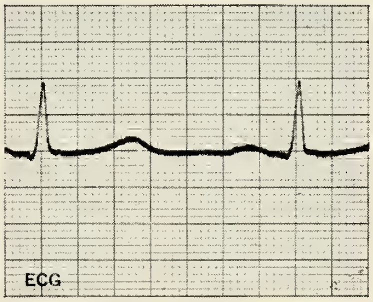

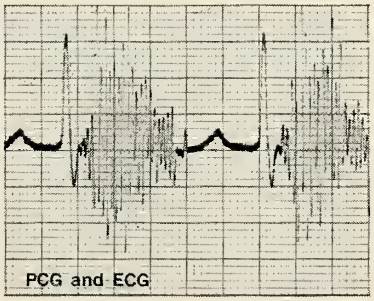

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PERSONAL MENTION

D. W. Douglas, M.D., Monroe,
a past president of the Monroe County Medical Society, has been appointed to the 1966 Red Cross National Convention Committee.

Gerald Mayer, M.D., Ludington,
has been appointed the new coroner for Mason County, to serve until the 1968 elections.

Marjorie Balmer, Dearborn,
is a director of the American Association of Medical Record Librarians.

Lynn A. Ferguson, M.D., Grand Rapids,
has been re-elected secretary-general of the American College of Gastroenterology;

Steven J. Figiel, M.D., Dearborn,
was renamed to another term as trustee. The annual meeting was at Bal Harbour, and the next will be in Philadelphia.

Melvin Selzer, M.D., Ann Arbor,
addressed the 4th International Conference on Alcoholism and Road Traffic at Indiana University. He spoke on "A Depression-Aggression Syndrome," related to accidents caused by alcoholics.

Francis P. Rhoades, M.D., Detroit,
President of the Wayne County Medical Society, has been appointed by Mayor Cavanagh to the Detroit City Plan Commission.

Richard J. Allen, M.D., Ann Arbor,
will direct a special pediatrics research project at the University of Michigan, supported by a recent $13,584 grant from the U. S. Department of Health, Education and Welfare. He is evaluating amino acid pools in various clinical states of phenylketonuria.

B. J. McCarthy, Detroit,
vice-president of Michigan Blue Cross, is a member of the Technical Advisory Committee about Reimbursement to the HEW on the Implementation of Medicare. Six such committees have been appointed.

William J. Mills, Jr., M.D., Alaska,
and formerly of Ann Arbor, has received the Navy's second-highest peacetime award, the Legion of Merit, for his work in the field of cold weather injuries.

H. Marvin Pollard, M.D., Ann Arbor,
is the chairman of the Clinical Fellowship Committee of the American Cancer Society for 1966.

Reuben L. Kahn, S. D., Ann Arbor
was honored by the Greater Detroit Physicians Committee of the American Friends of the Hebrew University in Israel when the Committee announced that the Reuben L. Kahn Laboratory in Immunology is being established at the University.

James K. Sutherland, M.D., Flint
was in the news recently when art experts decided that a painting he bought 30 years ago was a lost work of the 16th century artist Lorenzo di Credi. An art expert uncovered di Credi's signature while cleaning the madonna-and-child painting.

James S. Feurig, M.D., East Lansing, and
S. Martin Lindenauer, M.D., Ann Arbor,
have been appointed medical coordinators for the Olym Medical Archives at MSU and U-M, respectively. The tional O. M. A. organization hopes the lifelong medical r ords of Olympic athletes will answer questions about ph ical training, fitness, etc.

Robert C. Prophater, M.D., is a new member of the B City Commission, elected to serve the third ward.

Carl A. Moyer, M.D., head of the department of surgery the Washington University School of Medicine, is returni to the Upper Peninsula as director of research at Michig Technological University at Houghton. A native of Baraga, received degrees at Northern Michigan University and t U-M Medical School. His work at Tech will deal primar with bio-engineering.

Alexander Dukay, M.D., associated with the Ypsilanti H pital since 1953, is now the new medical superintendent the Ypsilanti State Hospital. He was appointed by Rob A. Kimmich, M.D., State Mental Health Director.

William Kavanaugh, M.D., Kalamazoo, is president of t Kalamazoo YMCA, which plans a campaign in 1967 to c struct a new building.

Daniel Rousseau, M.D., Mt. Clemens, is the new chairm of the board of the Michigan Cancer Registry. Also elect at the recent annual meeting were **Robert J. Bloor, M.** Detroit, vice chairman; **Henry J. Vanden Berg, Jr., M.D.,** w head up the statistical registry; **D. L. Hinerman, M.D.,** A Arbor, the pathology registry and **Viola G. Brekke, M.** Highland Park, the cytology registry.

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References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

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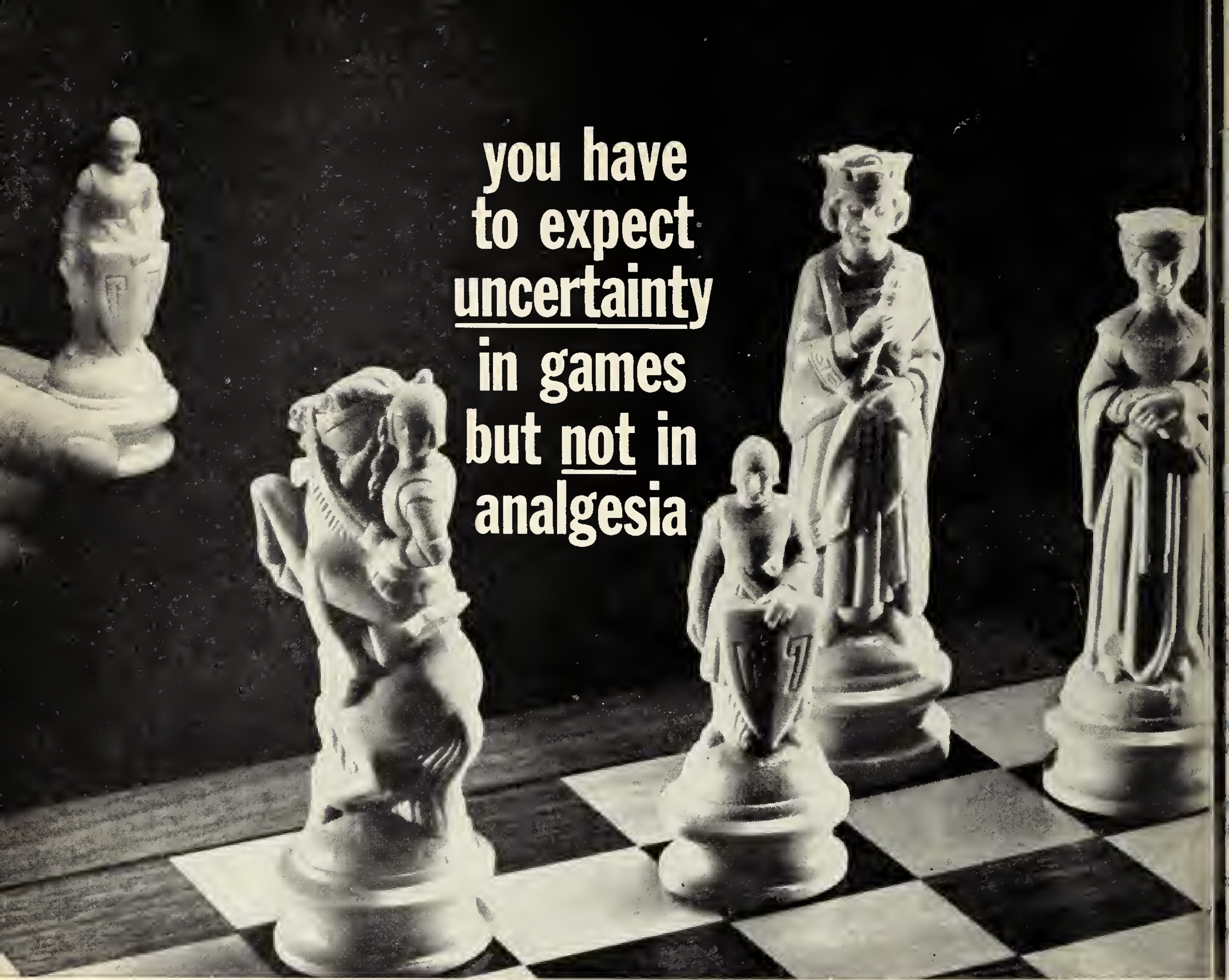

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PRESIDENT'S PAGE

Good Prescription;

Many, many times, in hospital corridors and at county medical society meetings, I have been asked: "Shouldn't our State Medical Society and the A.M.A. confine their activities and energies to scientific matters?"

And just as many times, if not more, I've been asked the same question, really, with a sort of reverse twist: "Shouldn't we keep from getting more deeply involved in community or political affairs?"

My good friends know that I personally am strongly convinced that a physician should not, and in fact cannot, escape a dual responsibility—on the one hand to his science and his patients, and on the other to his conscience and his community.

They also know, I am sure, that neither can be neglected without the other suffering.

* * *

WE SIMPLY MUST attend meetings, read our journals, and keep up to d so as to maintain the proficiency of our medical practice. It has always seen to me that we must also make it a point to keep ourselves informed about, be concerned with, the issues and events which shape the moral and social hea of our communities, state, nation and world.

The doctor of medicine is, after all, particularly well equipped to make portant contributions to the society in which he lives, as well as its individ members.

We follow our profession because we are concerned about people. The by day activities of our busy lives make it necessary that we be effective c municators. We have received an analytic education, and our study can ne cease.

Finally, and the importance of this cannot be overemphasized: our communi have rewarded us with respect.

* * *

AS THE ISSUES of 1966 arise in our communities and in the legislative h of Lansing and Washington, therefore, let us participate in their solution. friends and neighbors expect us to speak up and express our views on what believe to be right or wrong.

Our efforts to be good physicians never slacken. In the year ahead let us write the following prescription:

"Put a little more of ourselves into community activities."

That's good medicine.

Luther R. Leader M

Editor's Note: Keenly interested in good government and community service, MSMS President Leader is shown here visiting with Governor Romney during the MSMS Centennial Session.

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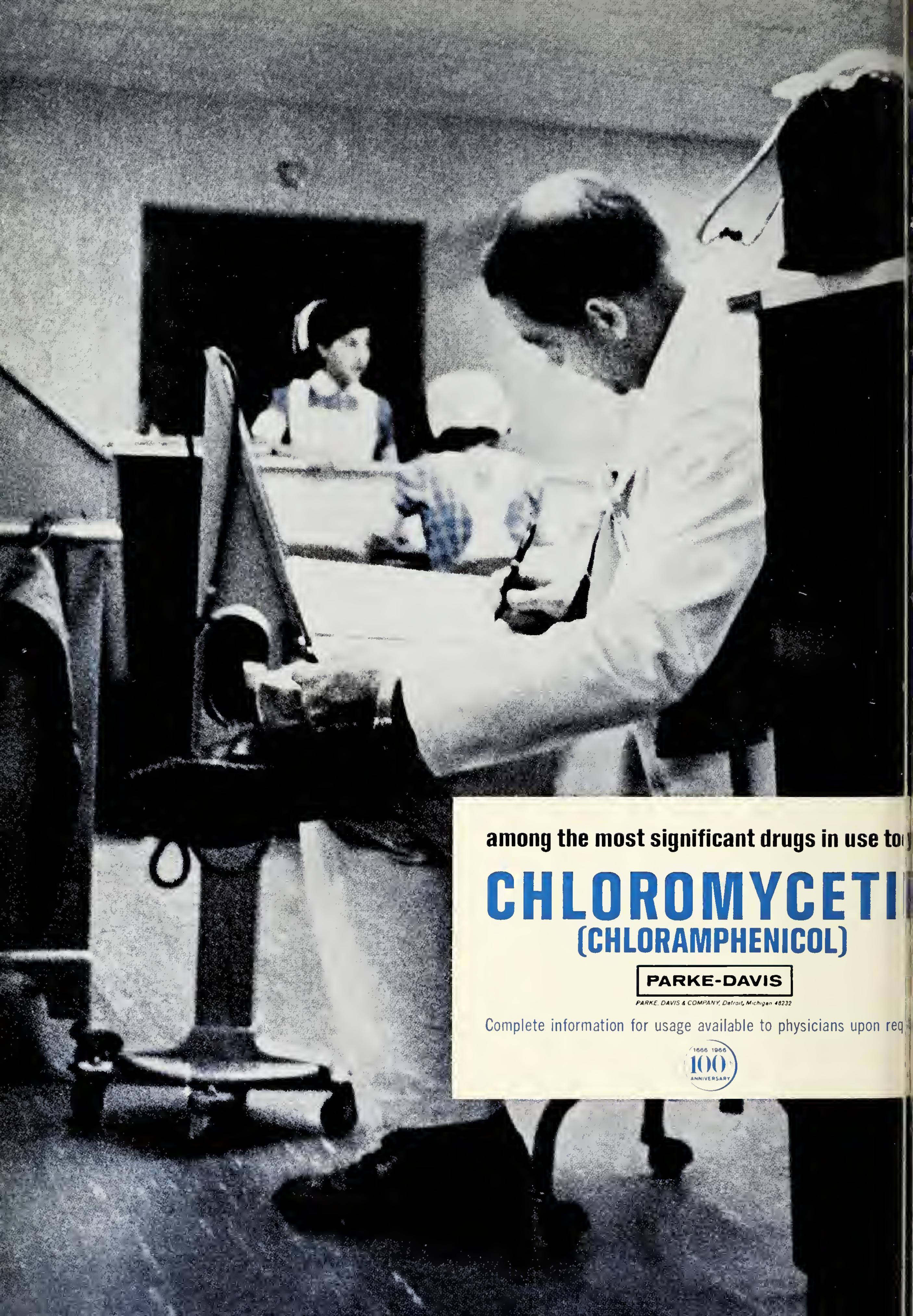

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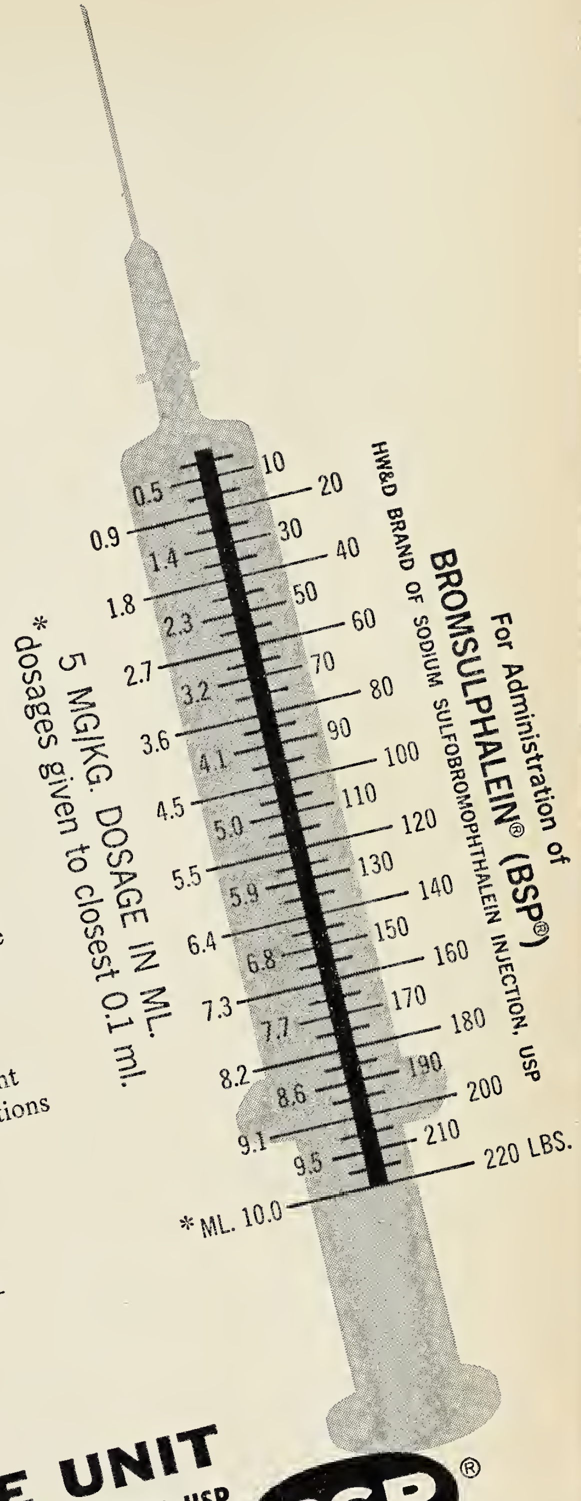
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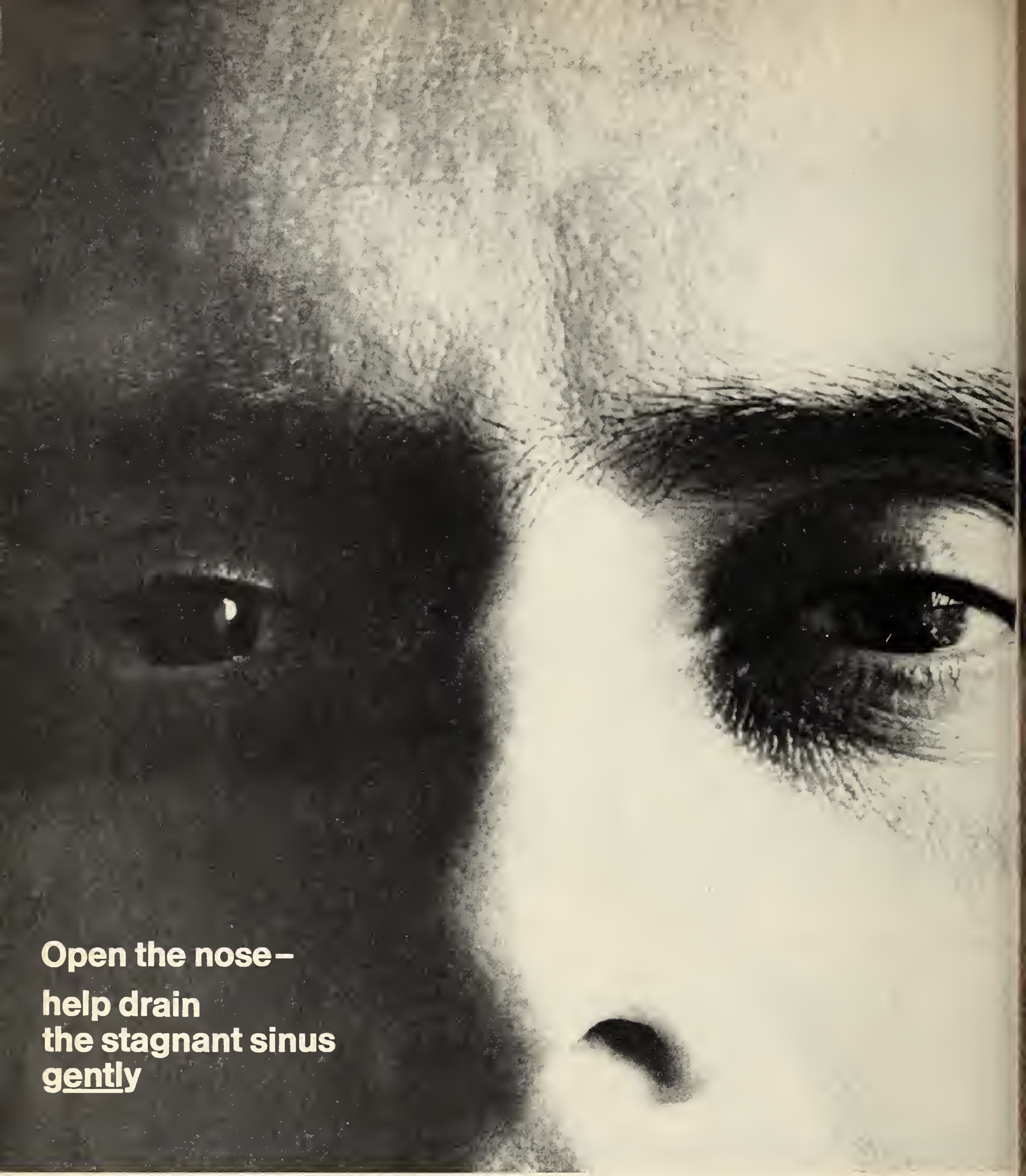

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*Proctor, D. F.: The Nose, Paranasal Sinuses, and Ears in Childhood, Springfield, Ill., Charles C Thomas, 1963, p. 34.

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EAST LANSING
MICHIGAN

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siness Manager
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e cover on this issue depicts one
the finest examples of ancient
eek ceramic art and is from a
se painted by the Fifth Century
ist Sosias. The scene portrays
Greek Hero Achilles bandaging
arm of Patroclus, his friend. The
sign was submitted to Michigan
dicine by Gerald P. Hodge, asso-
te professor of medical illustra-
n at the University of Michigan
dical School. He has been serv-
as president of the Association
Medical Illustrators, an interna-
nal organization.

Published monthly, except two extra issues to be published in October and December, by the Michigan State Medical Society
its official journal at 2642 University Ave., Saint Paul, Minn. 55114. Second class postage paid at Saint Paul, Minnesota.
arly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union,
.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, ex-
anges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East
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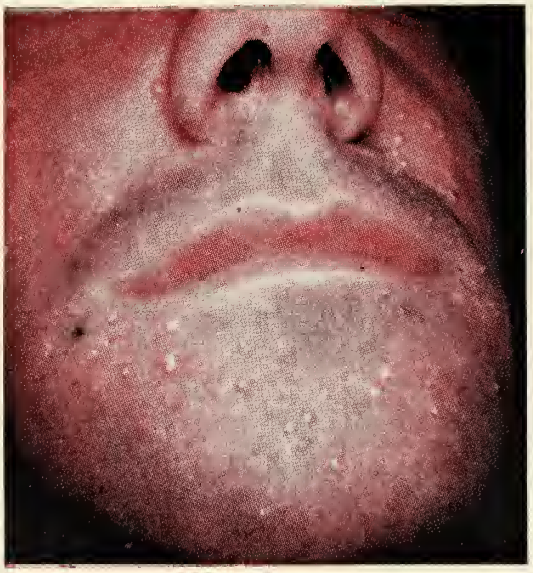
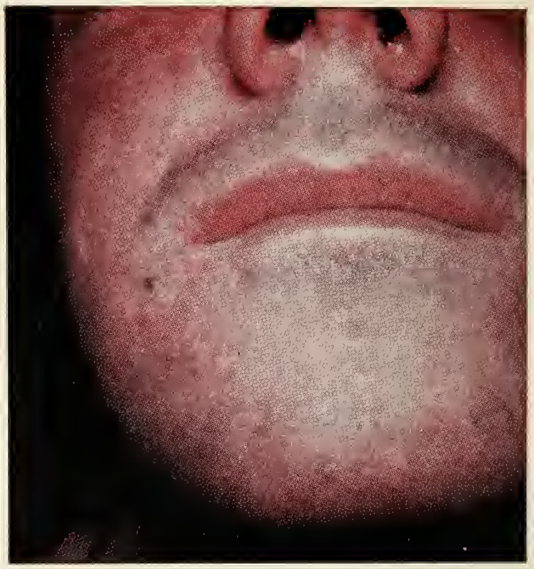
TOPICAL
TREATMENT



PRIMARY PYODERMA

TYPICAL
RESULTS



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HE FORUM QUESTION THIS MONTH:

Question: How can the medical schools interest more students in General Practice?

T. Knobloch, M.D.

y City

In order to revitalize and resuscitate the general-, medical schools must elevate and equalize his ;tus, image and remunerative opportunities to a r with his specialist colleagues.

His education and training must develop his abiles and capacities to assume a position of command d captaincy of the medical team in rendering total mprehensive medical care directly to the patient. ecialty medical services should revolve around his ection as hub of the wheel. He must have equal portunities, advantages and respect on hospital affs. He must not be relegated to a subservient and ferior position of bird dogging for the specialist. In other words, accentuate the positive and obliter- the negative.

mes R. Dehlin, M.D.

adstone

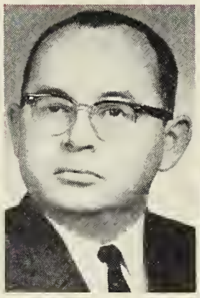
My first impression is that Medical Schools must st be convinced that the general practice of medie is a necessary part of medical practice. If this true, then smaller communities that cannot have e varied specialties on immediate call need general actitioners. One must be able to treat the patient cording to his professional ability and training. spital privileges are a necessity. After four years exposure to excellent teachers, research physicians d specialists, one needs a preceptorship with setted general practitioners.

Most important of all is that the general practiner must be convinced of his value and must be lling to take part in continuing education.

bert E. Fisher, M.D., F.A.C.P.

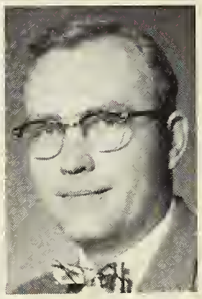
ttle Creek

Graduates should be required to spend a few years general practice before starting specialty training teaching (including teaching of interns and resints by senior residents). I feel that a proportion students who enter medical school with their minds ll open or with the intention of becoming general actitioners are influenced by the attitude of the culty, unintentionally, either to specialize or to go to the research field, not because of the need, but cause it is more advantageous financially or statusse.

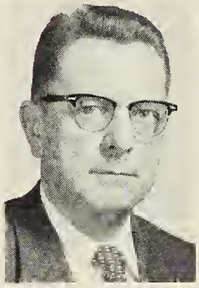


JACK M. STACK, M.D., Alma

H. T. KNOBLOCH, M.D., Bay City



JAMES R. DEHLIN, M.D., Gladstone



ROBERT E. FISHER, M.D., Battle Creek

If the faculty were more familiar with the challenges and rewards of general practice, they would be less likely to dwell upon the glories of specializing and research.

Van O. Keeler, M.D.

Otsego

Medical schools will produce family physicians when their faculty and administration are convinced that this product is in demand and desirable. Medical educators today appear to be bent on training men for the 18 specialties and several sub-specialties.

If you allow me to assume for a moment that the answer to the problem lies in producing more physicians suited for general practice, and further assume that medical schools are interested in this goal, then steps could be taken, such as: (1) Admission boards could select men expressing an interest in general practice. (2) Hospitals affiliated with medical schools could set up residencies in general practice. Such a system is operated by Louisiana State University with the Charity Hospitals in Louisiana. (3) Encourage general practice departments in medical schools to

(Continued on Page 167)

Anatomy of
Low Back Pain #1
the sedentary life
is often the seat of
low back pain

The human spine is not engineere prolonged sitting at desks, pianos, t writers and drafting boards. The stre set up by the heavy, forward-tilted l and trunk, balanced precariously o insufficient base, result in strain of dorsal musculature, particularly at low lumbar level.

The unusual muscle-relaxant and a gesic properties of 'Soma' make it e cially useful in the treatment of low l sprains and strains. 'Soma' is wi prescribed ☐ **to relieve pain** ☐ **to r muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for manageme muscle spasm, pain, and stiffness in a varie inflammatory, traumatic, and degenerative m loskeletal conditions. It also may act to norm motor activity in certain neurologic disturba

Contraindications: Allergic or idiosyncratic tions to carisoprodol.

Precautions: 'Soma', like other central ne system depressants, should be used with ca in patients with known propensity for takin cessive quantities of drugs and in patients known sensitivity to compounds of similar ch cal structure, e.g., meprobamate.

Side Effects: The only side effect reported wit frequency is sleepiness, usually on higher recommended doses. An occasional patient not tolerate carisoprodol because of an indiv reaction, such as a sensation of weakness. rarely observed reactions have included dizzi ataxia, tremor, agitation, irritability, headach crease in eosinophil count, flushing of face, gastrointestinal symptoms.

One instance each of pancytopenia and l penia, occurring when carisoprodol was ad istered with other drugs, has been reported, a an instance of fixed drug eruption with carisop and subsequent cross reaction to meprobar Rare allergic reactions, usually mild, have incl one case each of anaphylactoid reaction with shock and angioneurotic edema with respir difficulty, both reversed with appropriate the In cases of allergic or hypersensitivity react carisoprodol should be discontinued and appr ate therapy initiated. Suicidal attempts may duce coma and/or mild shock and respira depression.

Dosage: Usual adult dose is one 350 mg. t three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white ta and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strai

SOMA

(CARISOPRODO

Wallace Laboratories, Cranbury, N
26

ORUM/continued

llow the general practice section to admit patients o medical school hospitals. It does no good to tell student that general practice is worthy of followng while he observes that M.D.'s are ridiculed and llowed to admit patients only at St. Elsewhere. The udent must be convinced that not all general men re carving their financial future with a scalpel.

The demand for G.P. material is great. Many mmunities, including my own, are begging for ore physicians at a time when the steadily dwindlg supply is at an all-time low.

ack M. Stack, M.D.

lma

The first thing the medical schools should do to terest more students in general practice is to stop scouraging those who are already interested. Many ung men enter medical school with the idea that ey would like to be general practitioners. They e soon met with a barrage of opinion from resints and professors who have never been in private actice telling them that they would not be able to actice good medicine, they would see no interesting ses, and that advances in medicine are being made o rapidly for them to "keep up." The student soon ts the idea that the L.M.D. is someone who didn't ite make the grade and cannot possibly be practicg a good quality of medicine.

The student should be taught that general practice the most demanding and challenging position in edicine today, that the family doctor is the full ysician and that the specialists are his helpers, and at most young families today are searching in vain r one physician on whom they can call and rely their doctor and medical adviser. The good genal practitioner does not lose prestige in the eyes of s patients when he refers a problem requiring ecial skills and areas of knowledge. He should be ught that he can handle 80 to 90 per cent of their edical needs, that he can treat cases in his office at could not be treated effectually in the medical centers of the world 25 and 50 years ago, and that he can prevent diseases that devasted all in their path only a few years ago.

Another Comment

From a Southern Michigan Doctor

Having a Professorship of General Practice in the medical schools, which has been suggested in the past, seems to me to be a visionary project which is not going to meet with acceptance from medical schools generally.

The only really useful thing that I have been able to discover is that in those schools where there is a preceptorship in general practice during summer vacations sometime in the latter part of the student's course, students who are associated with general practitioners and see the wide variety of work done and the satisfactions secured from it, were motivated to go into general practice after graduation, more than in schools where this was not carried out.

UPCOMING QUESTION:

The Forum question for the May issue of MICHIGAN MEDICINE will be "How can we as physicians impress people with the dangers of cigarette smoking?"

Your opinions are invited for this monthly feature. Write down your suggestions in a letter and mail before March 25 to MICHIGAN MEDICINE, 120 West Saginaw Street, East Lansing.

B. M. Harris, M.D., Chairman
Publication Committee

Attention Readers:

Notice of change of address should be sent promptly to the Michigan State Medical Society, P.O. Box 152, East Lansing, Michigan.

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- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

TIME NOW TO BEGIN '66 ART SHOW ENTRIES

Each year the number of entries in the annua Michigan Doctor-Wife Art Exhibit has grown so tha now the show offers a varied and stimulating surve of current art trends.

This year the show will be held on September 26, 27, 28, 1966, in Grand Rapids. All delegates and visitors to the MSMS meeting are invited to view it

The Art Show Committee is asking for entries o original works in the following categories: painting drawing, sculpture, wood carving, ceramics, weaving photography and jewelry-making. An advance registration form will be sent to all Michigan doctors a a later date.

If you have any suggestion or questions regarding this exhibit please write to Mrs. F. A. Hutchinson 2518 Elmwood Drive, S. E., Grand Rapids.

Lauds Medi-Labels

The January issue of the "Association Newsletter," published in Fair Haven, New Jersey, told all association executives about the MSMS Medi-label project. It stated:

"As a public service, members of the Michigan State Medical Society are placing a medical data sticker on the driver's license of their patients. Designed and supplied by MSMS, the labels are invaluable in emergencies. Doctors use them to indicate such information as blood type, tetanus immunization dates, allergies, contact lenses, etc. The first one was given to the Secretary of State by his personal physician. Posters explaining the label were published by the Michigan Department of Public Health and displayed throughout the state."

MSMS Adopts Policy On Psychiatric Care, Treatment of Children

The Michigan State Medical Society's Council, acting on the recommendations of the Society's Mental Health Committee, has adopted a policy statement regarding the psychiatric care and treatment of children.

A long and intensive study by the Mental Health group had revealed that there is frequently failure to properly recognize the significant differences between adult, adolescent, and child psychiatric care. The conclusion was reached that most of the published material deals with adolescence and neglects the pre-school and beginning school age groups.

Primarily, the State Medical Society's Mental Health experts concluded that different types of facilities and programs are necessary for the adolescent groups and for the pre-adolescents (roughly ages 9 to 14), with children aged eight and under, requiring considerably more personal attention.

In setting forth its policy recommendation, the Committee pointed out that an attempt at age groupings can only be roughly correct and that each child should be placed in a program according to his own particular level of maturity.

The new State Medical Society policy follows:

1. Early recognition, prompt diagnosis, treatment, and rehabilitation is a fundamental medical principle which applies in the care and prevention of mental illness in children and adolescents.

2. The community legally defines all individuals under 18 years of age as children. Medicine recognizes that the needs of children vary with maturity, which may be *roughly* approximated by age groupings:

0-5 years — preschool child
6-8 years — beginning school child
9-14 years — pre-adolescent and
early adolescent
15-18 years — adolescent

3. Psychiatric services for children and adolescents must include (a) out-patient services in clinics and the psychiatric office; (b) in-patient services, appropriately organized for children and adolescents; (c) day care services and group care homes.

4. Psychiatric hospitals for children and adolescents, to provide a full spectrum of services and to achieve maximum flexibility, must (a) be located near the centers of population they serve; (b) maintain close working and professional relationships with the neighboring medical school, state mental hospital, child guidance cliincs, public school systems, courts, and case-work agencies.

5. Current state mental hospitals programs for

(Continued on Page 173)

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.

ABBOTT

mood elevation

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DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

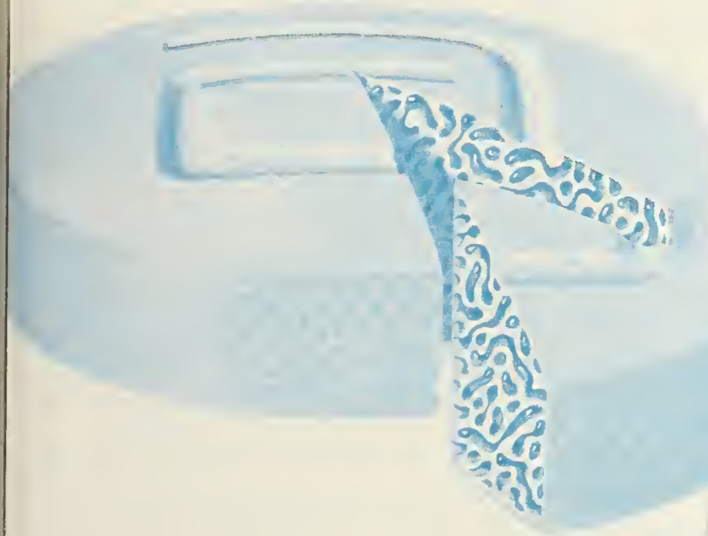
Calms anxieties; controls compulsive eating.

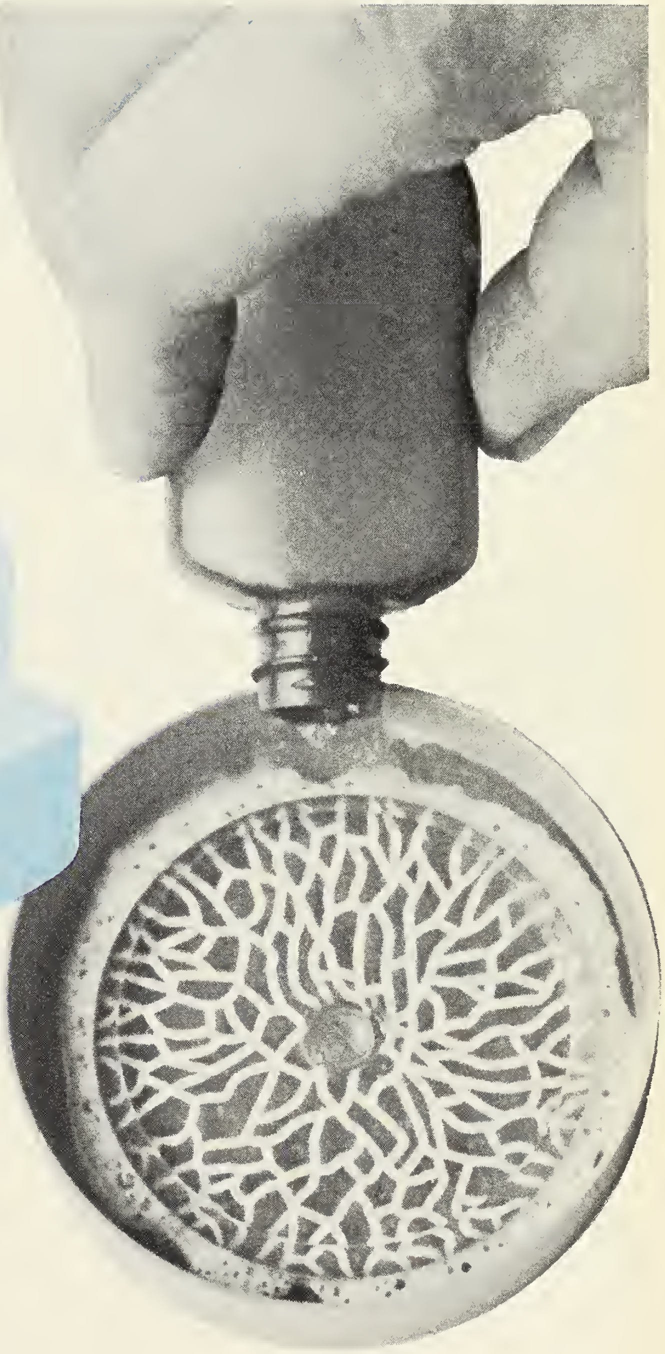
Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.

controlled release

ot all long-release vehicles are ıe same. Here is why the Gradumet ; different and what it means ɔr your overweight patients.





he release action is purely physical and relies on nly one factor common to every patient: gastrointestinal fluid. There is no dependence on enteric oatings, enzymes, motility, or an "ideal" ion conentration in the gastrointestinal tract.

Your patients get a measured amount of mediation, moment by moment, throughout the day. They are not subjected to ups and downs of rug release . . . or to erratic release from patient ɔ patient . . . or to erratic release in the same atient from day to day.

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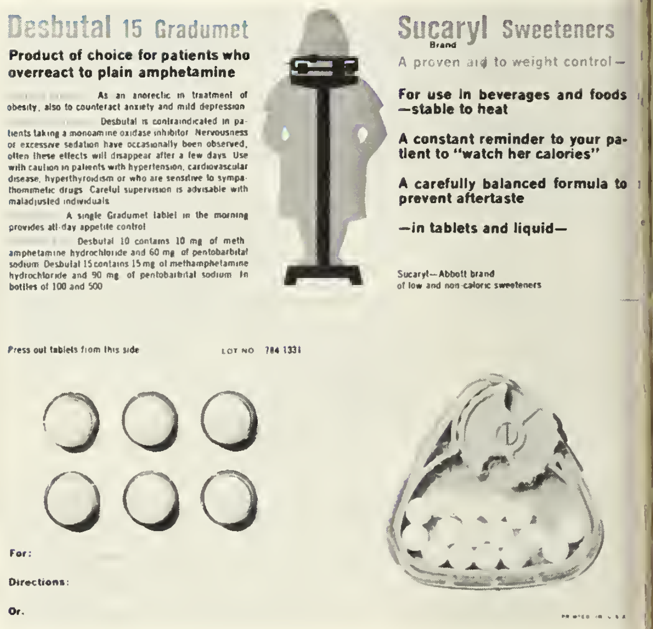

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A single Gradumet tablet in the morning provides all-day appetite control

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PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

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Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445. Sucaryl—Abbott brand of low and non-caloric sweeteners.

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ATE SOCIETY/continued

ldren and adolescents must be fully recognized d supported with funds and staff. It is the state ntal hospital that backs up the community services h facilities for the child that needs extended care.

. All operating programs for neurotic, psychotic, d brain-damaged children and adolescents must be listically supported with funds and recruitment of ff. These include special classes in schools, trained ffs for juvenile courts, and foundling homes.

There is a definite need for additional residential ilities in our communities.

. Training programs are urged to upgrade present sonnel and to provide additional needed manwer.

MEDISCENE

arch 10-11—Conference for Operating Room Nurses, Michigan Nurses Association, Pick-Fort Shelby Hotel, Detroit.

arch 24-25—5th Annual Michigan Conference on Maternal and Perinatal Welfare, Durant-Pick Hotel, Flint.

ril 4—45th Annual Beaumont Lecture by Walter Seegers, M.D., Wayne County Society Building, Detroit.

April 6—Genesee County Medical Society Cancer Day, Hurley Hospital, Flint.

April 13—Annual Meeting, Michigan League for Nursing, Hurley Hospital, Flint.

April 18-22—Spring Conference, Michigan Nurses Association, Civic Center, Lansing.

April 24—Michigan State Medical Assistance Society, 9th Annual Educational Seminar, Empire House Motel, Bay City.

May 2-7—Western Michigan Health Fair, Muskegon.

May 11-13—Michigan Public Health Association Annual Meeting, Pick-Fort Shelby Hotel, Detroit.

May 13-14—Michigan Kidney Foundation Medical Symposium, David Whitney House, Detroit.

May 14-15—Michigan Association of the Professions Congress, Pontchartrain Hotel, Detroit.

May 26—Conference on Medical Writing, Kellogg Center, East Lansing.

June 22-25—Michigan Association for Retarded Children Conference, Northern Michigan University, Marquette.

July 16-17—Upper Peninsula Seminar.

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Details for the Fifth Annual Michigan Conference on Maternal and Perinatal Welfare March 24-25 in Flint, were discussed by members of the MSMS Maternal Health Committe Chairman W. W. Jack, M.D., of Grand Rapids, is at the head of the conference table in th Council room at the MSMS Headquarters in East Lansing. Doctor Jack wishes to stress tha there will be no registration fee.

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Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its antianxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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A Monthly Commentary

Reporting As Ordered

By Hugh W. Brenneman
Executive Director

"Show Windows"*

Fourteen county medical societies—serving the bulk of the physicians in Michigan—publish county medical society bulletins or newsletters which serve as "show windows." They are "show windows" of the organization to the members, and to some extent, of the organization to the public.

With the exception of the weekly Detroit Medical News, these publications are issued, usually, on a monthly basis.

The material presented is remarkably similar, with emphasis on announcements relating to the functioning of the county medical society. These bulletins perform a valuable service. Although it's hard work to edit and publish a bulletin, the editors are usually forgotten when kudos are being distributed. If I stopped right there I probably would be ahead but because few people are in the position of reviewing all of these bulletins, perhaps a few observations would not be amiss.

1. They are all written in good standard English.
2. The editorials reflect sound, progressive thinking, with much recognition of the public interest.
3. The information is valuable, accurate, current and well assembled.
4. In many instances the layout of the material has been left to the mercies of a printer who lacks imagination, art skill, space, time and concern. He is more concerned with his "register" than what h presses are registering.

Now the conclusion is apparent: with a little gui ance from a good layout man who has experien and taste in laying out editorial and advertising ma terial, a tremendous improvement could be made i the appearance and readability of the publication.

As "show-windows," they should look modern, a tractive and dignified.

It is doubtful if the net cost to the society at th end of the year would be appreciably greater. I fact the added attractiveness to advertisers migh make the net cost less. Any community large enoug to sponsor a printed bulletin will have persons in who are qualified in layout . . . advertising layou men who work for newspapers . . . or for stores . . . o for advertising agencies . . . will usually be glad t "moonlight" in this publication for a reasonable fe

Membership and Services

Speaking of valuable services, few doctors are awar of the tremendous change that has occurred in th services rendered by the American Medical Associa tion during the past 20 years. This great organiza tion used to be, to all intents and purposes, a publish ing house for the JAMA and for several specialt medical journals. This was a good service well don but it did not compare with the modern AMA.

Today membership in the AMA helps physician render a better brand of medicine. They can kee informed on professional matters and also on legis lative activities, public health, socio-politico-economi matters, toxicology and cosmetology, medical lega problems, taxes and the multitude of non-medical scientific subjects that are much a part of medica practice.

Without additional charge, the AMA member re ceives the JAMA, AMA News, Today's Health, a package lending library of periodicals, a question an answer service, a physician placement service, majo clinical meetings, special conferences and symposia.

When the AMA develops and publicizes policie and information (which it does constantly) on medical education, mental health, national security, occupational health, rural health, and ways to improv medical service, it is benefiting patients as well a physicians.

To a large extent these same services, attuned to the area of a state, are carried out by the constituent organizations of the AMA—its state medical societies. Today's Michigan State Medical Society, with its broad spectrum of committees, observers, programs and personnel, is a far cry from the two-room office of the World War II period, occupied by a harrassed executive secretary, a secretary, typist and part-time bookkeeper.

This brings to mind the necessity for a constant review of those doctors in each community, who are

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They are: Detroit Medical News, Wayne Medical Society; The Bulletin, Genesee County Medical Society; The Bulletin, Oakland County Medical Society; Bulletin, Washtenaw County Medical Society; Bulletin, Bay-Arenac-Iosco Medical Society; The Bulletin, Kalamazoo Academy of Medicine; Synopsis, Lenawee County Medical Society; The Bulletin, Calhoun County Medical Society; The Bulletin, St. Clair County Medical Society; The Bulletin, Berrien County Medical Society; Macomb County Medical Society Newsletter; The Bulletin, Saginaw County Medical Society; Bulletin—M.D., Muskegon County Medical Society; Bulletin, Kent County Medical Society; Medicina, Ingham County Medical Society.

t members of the county, state or AMA as possible w members. There is a constant increase in the mber of members of these organizations but this ould be stepped up.

In 1906 the sage Elihu Root wrote: "It is not the anger who says, 'go there,' or, 'do that,' who is eyed, but it is the old acquaintance who says 'come th me', or, 'let us do thus and so,' who is followed."

Science is supposed to have taken on glory lost by ctors, machines are said to be replacing physicians heroes of healing, and greater publicity is being ven kidney machines than the men who run them. vertheless, the physicians are still making the deci- ns and their need for personal association with one other—on every level—has never been greater.

hart of Membership in MSMS over Past 10 years

1955	5375
1956	5541
1957	5694
1958	6668
1959	6865
1960	6916
1961	6973
1962	7126
1963	7221
1964	7385
1965	7565

overnment Medicine

Under the state and federal laws, prior to the ssage and implementation of Title 19 of Medi- re, 2,145,000 persons were receiving old-age assist- ce and 265,000 elderly were receiving aid as med- l indigents . . . total, 2,410,000. If and when the w law becomes fully operational this number will crease to 35,103,000. Of these, 27,500,000 will be the medically indigent, *not* the welfare category.

The timetable started January 1, 1966, with the inclusion of federal-state programs for the blind, disabled, and families with dependent children.

July 1, 1967, requires a minimum of physicians' services, inpatient and outpatient hospital services, skilled nursing home services for adults, and lab and x-ray services.

January 1, 1970—Federal funds cease to any state not complying with the above for all federal-state welfare programs.

July 1, 1975. Federal funds cease to any state that hasn't extended the above benefits to all medically-indigent persons.

You probably knew the above. I cite it only to emphasize that during the next ten years more new people will be placed under complete government-medical care than at any previous time in the history of the United States—and this is over and above Medicare . . . and without any expansion of the present laws.

That's why decisions made today in the methodology for the coverage of these persons is so important.

COMING IN APRIL

The lead article in April will be an authoritative and useful discourse on "The Role of Kidney Biopsy in Modern Medicine" by Drs. Greene, Lapco, and Weller of Ann Arbor. Dr. Goodsell of Saginaw will document a "Fracture of the Patella Forty-four Years Later," and Drs. Doshi, Alexander and Schaefer of Detroit recount their experience with "Dissecting Aortic Aneurysm in a Small General Hospital."

Also watch for an article from Wayne State University School of Medicine on "Respiratory and Cardiac Resuscitation" and other interesting material as well.

ADVICE FOR CONTRIBUTORS

1. Address scientific manuscripts to e Publication Committee, Michigan ate Medical Society, 120 West Saginaw reet, East Lansing, Michigan.

2. Submit original, double-spaced pewritten copy and one carbon copy on tter size (8½ x 11 inch) paper.

3. On page one, include title, authors, egrees, academic titles, and any institu- onal or other credits.

4. Authors are responsible for all atements, methods, and conclusions. hese may or may not be in harmony ith the views of the Editorial Staff. It hoped that authors may have as wide titude as space available and general olicy will permit. The Publication Com- ittee expressly reserves the right to alter r reject any manuscript, or any contribu- on, whether solicited or not.

5. Illustrations should be submitted in the form of glossy prints or original sketches from which cuts, or plates, will be made by Michigan Medicine. Michigan Medicine will pay the first $25 of the engraving bill, and the author shall pay the balance. An estimate of the cost will be submitted to authors before cuts are ordered.

6. References will ordinarily be limited to seven in number. Exceptions may occassionally be made.

7. Contributors will be notified as soon as practical if a manuscript is accepted for publication. Unused manuscripts will be returned. Every care will be taken with the submitted material but the Journal will not hold itself responsible for loss or damage to manuscripts.

8. Articles should ordinarily be less than four printed pages in length (3000 words).

9. References should conform to *Cumulative Index Medicus,* including, in order: Author, title, journal, volume number, page, and year. Book references should include editors, edition, publisher, and place of publication, as well.

10. Specify address to which galley proof should be sent. Proofs will be mailed to authors for correction before publication and should be returned to the editor in 48 hours. If proofs approved by the author are not received by the editor prior to deadline, publication of the article will be cancelled for that issue.

11. The editors welcome, and will consider for publication, letters containing information of interest to Michigan physicians, or presenting constructive comment on current controversial issues. News items and notes are welcome.

12. It is understood that material is submitted for exclusive publication in Michigan Medicine.

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he Revolution in Science and the Response of the Church

ORIGINAL SCIENTIFIC ARTICLE

y W. N. Hubbard, Jr., M.D.
nn Arbor

INTRODUCTION

The revolution in science can be comprehended ıly if we understand something of the basic nature science itself, and then examine the several manistations of science that have undergone radical ıange in the twentieth century.

In its most abstract form, science can probably be ɔnsidered accurately as a language that describes in ı internally consistent and noncontradictory manner ll of the sensory data that man can acquire. In ddition, this language must be able to express inferıces and hypotheses about cause-effect relationships ıat produce the data. These requirements have proıced a language which tends to utilize more and ıore mathematical symbols and which departs furıer and further from the imprecise language which e use in ordinary daily intercourse.

The language of science omits any assertions that re unavailable to confirmation by measurable obrvations. The scientific positivist would argue that ıis is simply the omission of unreality, but most of ıose who have examined this characteristic of scintific language will describe the exclusion as being ithout prejudice.

The problem of the nature of "being" or "existence" ı scientific terms is dealt with as the existence of nergy or mass, confirmable by objective observation f data that have time and position as components.

THE REVOLUTION IN METHOD

Now it must be emphasized at the outset that the ast majority of scientists have no particular interest ı this kind of verbalization. Rather, they translate hese basic hypotheses into methods of procedure and evote themselves to the method rather than to the nderlying assertions.

In the twentieth century it is method that has capıred scientific interests in fields from psychiatry to hysics. The first area of genuine revolution is, thereore, within the area of scientific method.

The fundamental method of science is accurate bservation and recording of events that are pereived by the five senses with which man is endowed. \s these observations were recorded over historic time, a body of empirical experience was developed. A large part of scientific effort today (in medicine particularly) is based on general observations that are accurate and recorded over a long time to constitute a body of empirical experience.

It was not until after the Renaissance that experimental phenomena were substituted for the empirical approach. In the experiment, the conditions are varied by the observer in order to test the effect of changing the components of the system. This movement from empirical experience to experimental experience represents one of the most profoundly powerful advances in scientific method. It was not until the nineteenth century that these experiments began to be important in human biology and it is only in the twentieth century that they have become really important to clinical medicine.

By the middle of the sixteenth century, through the middle of the seventeenth century, the importance of quantitation of experimental observations began to develop. By 1650 the view had been well developed by Descartes that unless observations were quantifiable they did not have a respectable place in science.

> *Since the five senses are notoriously unreliable, instruments have been developed in enormous and increasing variety and sensitivity which respond to physical events in an objective way, serving as an extension of the five senses. As a result, scientists deal more and more with events outside of direct human experience and their descriptive language is increasingly distant from that used for the experiences of everyday life.*

Finally, the strategy of scientific method in the twentieth century requires the examination of *components* of complex phenomena in order to accommodate to the requirements for exact measurement and objective description. The scientist is, therefore, frequently concerned with components of a phenomenon (such as cancer or heart disease) which are far removed from the complexity of the event as it occurs in real life. By examining the multiple components of such complex phenomena, reproducible and predictable descriptions can be achieved.

The methods used by scientists have historically been derived from the physical sciences and, in particular, mathematics and physics. As systems move from relatively simple events to very complex ones, the present scientific methods appear to be progressively unsatisfactory in explaining these complex events. Whether the methods derived from physics and mathematics do, in fact, provide a satisfactory method for describing complex living systems and the

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Presented before the Michigan Methodist Pastors' School, Albion College, Albion, Michigan, on August 1, 1965.

unique characteristics that define man remains to be ascertained. However this may be, the scientific study of man today as well as the physical events that surround him is dominated by the trends in scientific methodology.

THE REVOLUTION IN CONCEPTS

The second area of revolution in science is within the realm of concepts. If there is any area where the revolution in science includes an element of renunciation, it is within this field of scientific concept. What is renounced is the mystical and nonmaterial components of human life. Since nonmaterial events fall outside the logic of the scientific method, the scientific positivist is inclined to discount their reality.

At best, he will assume that these are very fuzzy descriptions of a set of events about which we have so little reliable objective data that it is not possible to come to a closely reasoned conclusion about them.

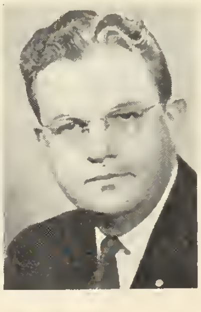
Modern science rejects the idealism of Socrates which gives primacy to some abstraction over the object itself. It also rejects the Aristotelian and Thomistic view of the physical world which is based upon a single act of creation. Rather, it conceives of energy and mass being the prime events in our universe, with our thought being contingent upon this circumstance.

The dualism of mind and body associated with Cartesian philosophy has gradually given way to the Kantian critique of the capacity of pure reason to either prove or disprove the existence of God. The Cartesian arguments for the existence of God are systematically discounted by Kant while the difference between objective and demonstrable reality and the contingent reality of reason is maintained.

> *At the present time, one finds a clear separation conceptually between those events with extension in time and space and those events which do not represent data from the five senses.*

This evolution of concept is now being re-expressed in a sort of neo-Thomism and in the existentialist philosophies. Descartes' assertion that "I think—therefore I am" is now being replaced by the pragmatic insistence on the primacy of individual existence. Fundamental to these concepts is the attitude of universal doubt and the contingency of all factual a sertion.

There is within the scientific concept no room f religious faith. Such faith must exist outside the sy tem of science. There is no conflict because there no relationship.



The Author
WM. N. HUBBARD, JR., M.D.

THE REVOLUTION IN KNOWLEDGE

From the revolution in method and concept, the has developed a completely novel rate of increase i factual knowledge. The methods of science have r moved the intrinsic restrictions of the five senses o the amount of data that can be collected. Compute have been developed which can process a number items of information that far exceeds the capacity a multitude of human brains. This explosion in th volume of objective facts available to the scientist h created a crisis in communication for two reasons:

1. The capacity of the human mind to absorb i formation is finite whereas the capacity of moder scientific method to produce information is ver rapidly increasing.
2. The relationship between the data and th phenomena of real life is increasingly indirect, so tha the interrelationship between historical events an those of the present becomes less and less meaningful.

As a result, many of the most fruitful investigator in terms of development of new information, kno little or nothing of the historical development of thei field and find no need to have such information. Sinc other scientists are generally aware only of the historical development of a foreign field, because they ar not a part of its current advancement, a very seriou communication problem exists. Even more defficul is the communication between scientists and nonscientists.

As scientific knowledge increases, however, it becomes more and more evident that the sheer accumulation of factual data cannot substitute for the integrative processes of the human mind. For instance, i is not possible to measure simultaneously the rate a which motion is taking place and the precise locatio of the moving object.

> *As a result, all scientific measurement contains an uncertainty as to the precise locus of time and place for a given object. This is now accepted as an uncertainty principle and has its own logical proofs.*

It furthermore was assumed traditionally that mathematical expressions were a complete system of symbols. More recently, it has been clear that any mathematical system that is as sophisticated as simple arithmetic is inherently open and therefore its symbols are, in a manner, no more reliable than those of other forms of symbolic expression such as common language. I am no mathematician and must refer you to Gödel's proof of this theorem.

So influential is this explosion in knowledge that ie adequacy of the printed word for communication s in serious doubt insofar as science is concerned. It s highly probable that other communication systems hich are quicker and more efficient (in that they espond more precisely to the need of the thinker) ill be developed within the field of science.

THE REVOLUTION IN SPECIALIZATION

The fourth area of revolution in science is the inrease of specialization. This is an almost necessary vent when one considers the enormous development n scientific method and scientific knowledge and nderstands the relatively static capacity of the human ntellect. Separation and alienation between scientific ecialists and between scientists and nonscientists is most serious problem. Increased understanding reuires the information which can be produced only y the specialist.

On the other hand, the integrative process itself ypically requires the utilization of scientific data from variety of fields.

Interestingly, there is a trend toward synthesis and mplification within science. With improved undertanding that is derived from better facts, one finds ery broad theories developing. The theory of matter, he theory of evolution and the role of DNA in conrolling life systems reflect these important integrative heories.

Literally a choice must be made between the kind f competence that can only come with specialization nd the Renaissance idea of the generally informed itizen.

> *One of the most important conflicts within science derives from this problem of translating the abstractions of scientific reality into the sort of reality that exists in everyday life.*

The disciplinary or specialized scientist is looked upon as pure or basic while the practictioner of science n real life is looked upon as mission-oriented and applied—the inference being that this latter is a more superficial effort. The conflict between pure or basic science and applied or problem-oriented science is of great importance. The pure scientist is likely to probe those questions where the state of scientific development allows some likelihood of fruitful effort. The practitioner, on the other hand, is almost forced to deal with those problems that are most important in real life. As a result, one finds in almost all fields, but probably most clearly in medicine, a lack of sympathy between the pure scientist who seeks improved knowledge and the practitioner scientist who seeks to solve real-life problems. Actually, these should be two components of an interlocking system, but as specialization increases this synthesis becomes more and more difficult.

THE REVOLUTION IN APPLICATION

The fifth area of genuine revolution in science is in its practical applications. In the simplest terms it can be asserted that all material events are subject to examination by the scientific method and, further, that all material events very probably form a single great interdependent system. It is, however, not at all likely that the events can truly be controlled. Rather, it will be increasingly possible to set the conditions in which the event will naturally occur and thereby appear to control its occurrence.

One of the most formidable aspects of this development of control of material events is the probability that consciousness and mind are related specifically to the brain which is a material substance with a time-space extension. The idea of behavioral science could then become a fact and *cogito ergo sum* would have to be inverted.

> *We should be prepared for the probability that what we call consciousness and mind will, in the course of scientific exploration, be more precisely defined in terms of the material events that take place in the brain.*

The importance of this control of material events for humanity is a matter of the very gravest concern. It will, by understanding the conditions which lead to the production of characteristics that have defined the human, be possible to mold the nature of the human being himself.

Sperm and egg banks are already a reality.

Mood control through drugs is rapidly increasing as a rational branch of pharmacology.

The insertion of information preformed in DNA is already achieved in viruses and in bacteria and theoretically can also be achieved in higher forms of life.

The knowledge of the psychologist of the dynamics of conditioning opens the way for a systematic manipulation of values and attitudes by whoever controls the information system upon which humans depend.

The probability of universal health and the absence of premature death alters basic human interrelationships.

THE REVOLUTION IN SOCIAL INFLUENCE

The sixth and final area of revolution in science is the influence of the scientist in our social structure.

The scientific basis of power in both a political and a physical sense has suddenly catapulted the scientist into the highest decision-making levels of our society. There is as blind a faith on the part of the general public in the capacities of science to resolve problems that confront them as there ever has been in the most primitive animistic religions. There is no doubt that the rigor, objectivity and intrinsic honesty of the scientific method would probably be very valuable if it could find application to our social problems.

Psychiatrists and mathematicians have been dealing recently with the theoretical basis of social conflict. The assumption is that the scientific method is applicable to the achievement of an "ideal" human state. This is, of course, an internally contradictory statement since the scientific method itself rejects the notion of Platonic ideals.

The long-term effect of this last portion of scientific revolution is impossible to foretell. It is this last area and the area of practical application that open the way for the obligations of the Church in its response to the scientific revolution.

THE RESPONSE OF THE CHURCH

The Church, as I understand it, is in part a human institution composed of those who are united by a common faith and in part is a mystical expression of the body of Christ. As a human institution and as the mystical body of Christ the Church is concerned with the eternal salvation of humans and with the human condition on earth. This humanistic quality of the Church gives it a unique responsibility for fostering human values. Science has nothing to offer in this field since the very idea of good or bad is foreign to our modern concepts of science.

In the Church we must find a continuing search for the man-God relationship that has been at the heart of theological speculation from the beginning of time. When God spoke saying, "Abraham, where art thou?" Abraham could respond "I am here." Is man today able to hear the seeking voice of God and is he able to respond with the assurance of ancient Abraham?

The Church must continue to deal with the meaning of primary cause. Neither primary cause nor ultimate being are susceptible to examination by the scientific method. What is without beginning and without end is beyond the logical system of the scientist. What is vital is that the theologian must understand that there is this clear separation between material events and spiritual ones just as there is a separation between the varying levels of consciousness in the mind and the physico-chemical events that underlie them. The actual mechanism of the interaction between mind and body is as much a mystery as the interaction between the Godhead and the universe.

The Church must be concerned with the whole problem of aesthetics and emotive reality. It should regain the ancient effort of the Church to be the fountainhead of beauty and style in the creative arts and the ultimate expression in poetry and music. It is within this field of aesthetics that the Church can offer an alternative to the nihilism that confounds modern artistic effort.

Most importantly, the Church must deal continually with the system of ethics that gives man the basis of making value judgments and establishing a system of moral behavior. The ideas of justice, mercy and humility which Micah identified as man's ultimate obligation all fall outside of the system of scientific logic. The sacredness of the individual and his self-fulfillment by being of value to his fellow humans is the foundation of an ethical system which is now largely the responsibility of the Church to maintain. The Church must educate its members and all of mankind to the understanding that for all its great power, science cannot produce the value judgments which allow man to distinguish himself from other animals.

It is the obligation of the Church in response to the scientific revolution to emphasize its humanistic concern with the nature of man. Science cannot deal with the uniqueness of any event except as part of a generalized experience. If there is any genuine conflict between religion and science, it is at the point of the religious assertion that man as man is unique.

It is the Church's dedication to human purpose, to the reality of human creativity and to the self-determination that comes from human consciousness that are an essential part of its response to the scientific revolution. Within science, competitive survival of individuals within groups and between groups is a fundamental tenet. The survival of the human race depends upon the rejection of this fundamental tenet and in its place the substitution of the brotherhood of all mankind.

The response of the Church to the scientific revolution is, therefore, to renew the great tradition of the Church. The man-God mystery that is the foundation of theology—the concern with aesthetics and the reality of emotive experience—a formulation of a system of ethics which allows human values to be rationally derived—and, finally, a continuing emphasis on the significance of the nature of man as a unique creature.

It has become unfashionable in our time to dwell upon mystical matters. The unsuitability of mystical interpretations of physical events which science has demonstrated need not be extended into a rejection of faith.

It is our faith in an ideal being which allows us to strive with direction rather than wander in a desert of aimless effort. It is this faith that substitutes pattern for chaos and gives meaning to what would otherwise be a transitory and meaningless episode in geologic time.

In responding to the scientific revolution, the Church must recognize it as the new Caesar. In order to render unto this new Caesar the things that it claims, it must be understood. It is as important that the Church reaffirm its recognition of those things which fall outside the province of this new Caesar.

ORIGINAL
SCIENTIFIC
ARTICLE

The treatment of chronic glaucoma with compounds containing epinephrine can result in the appearance of discrete or confluent conjunctival deposits of melanin, masquerading as metallic foreign bodies. Careful inquiry by the generalist or industrial physician regarding the patient's past ocular history will eliminate most of the confusion related to the use of this group of drugs.

Glaucoma And Conjunctival Foreign Bodies

By C. L. Giles, M.D.
Detroit

The recent resurgence of the use of epinephrine derivatives in the treatment of chronic glaucoma has resulted in the production of iatrogenic conjunctival "foreign bodies."

Lowenstein in 1927[1] first noted the correlation between topical application of epinephrine compounds and the presence of discrete, black pigment deposits in the conjunctiva. Although levorotary epinephrine (L-epinephrine) was known to reduce intraocular pressure in the early part of the century it was not used in the treatment of glaucoma until Hamburger[2] popularized the use of the drug in 1923. Its utilization was short-lived because of improper selection of patients, and it was not until 1958 when Becker and Ley[3] specified its importance in chronic simple glaucoma (and not narrow angle or congestive glaucoma) that epinephrine was considered a significant agent in the treatment of glaucoma.

While the presence of the pigmented conjunctival deposits presents no problem to the ophthalmologist employing the drug, the generalist or industrial physician, frequently the first individuals seeing patients with suspected foreign bodies, should be alerted to this clinical finding. It is the purpose of this report to illustrate and briefly discuss the origin of these deposits in the conjunctiva.

Three photographs (Figures 1, 2, 3) clearly illustrate the presence of the well-localized, black conjunctival deposits seen mainly on the palpebral (lid) conjunctival surface but also present on the bulbar surface. These can also appear in conjunctival cysts and are frequently conglomerate. Occasionally these deposits can be easily flicked out with a foreign body spud but frequently they cannot be removed without marked manipulation of the conjunctiva. It is only rarely that they can be implicated as a cause for a foreign body sensation. There is, therefore, no indication for the indiscriminate removal of these particles, but when there is an associated foreign body sensation a careful search must be made for the presence of another offender.

Corwin and Spencer[4] biopsied and studied the deposits histochemically. They concluded that the pigmented substance present was melanin and noted that with oxidation epinephrine was converted to melanin via the unstable substance adenochrone. When this substance was found within cysts it was not intracellular and these authors feel that cystic structures preexist with the epinephrine deposited within them.

With the increased use of the levoephinephrine compounds the incidence of these "foreign bodies" will increase. In order to prevent the needless re-

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moval of conjunctival melanin deposits masquerading as metallic foreign bodies it is important to carefully note whether or not the patient is receiving any of the epinephrine containing medications. The brand names of those compounds now available include: Glaucon (Haug), Epifrin (Allergan), Adrenotrate (Crookes-Barnes), Eppy (Barnes-Hind), Mytrate (Professional), Epitrate (Ayerst), and Lyophrin (Alcon).

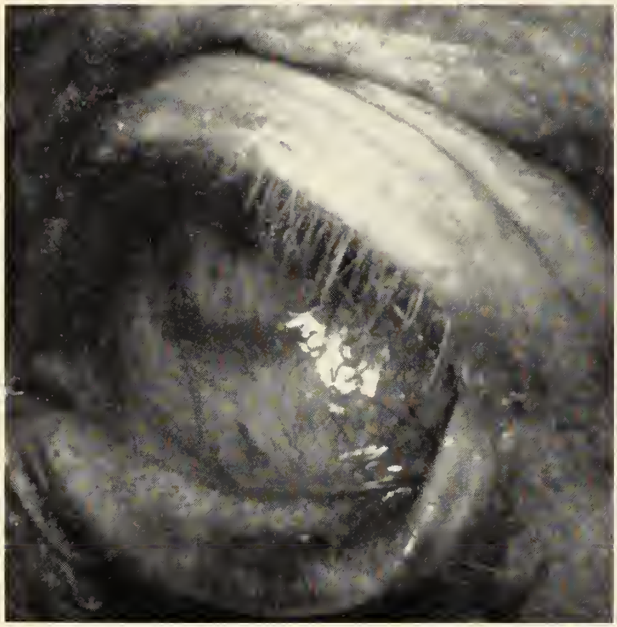

FIGURE 1: Conglomerate melanin deposit in conjunctiva of lower lid in patient receiving levo-epinephrine compounds for chronic glaucoma.

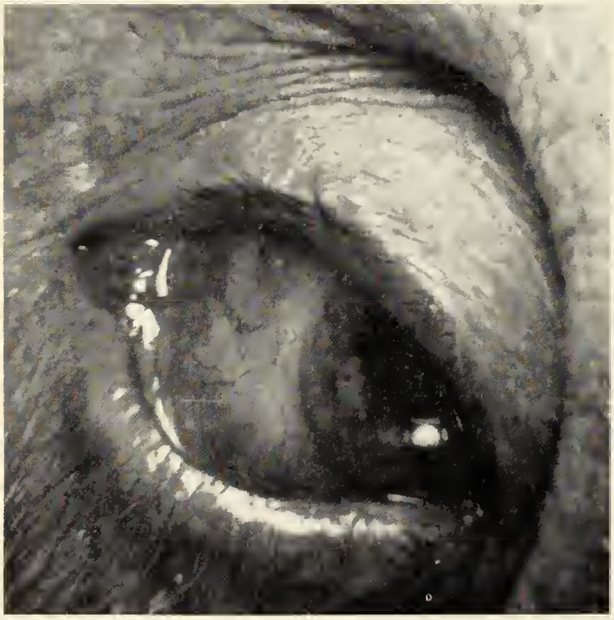

FIGURE 2: Single large deposit near caruncle of patient with chronic simple glaucoma.

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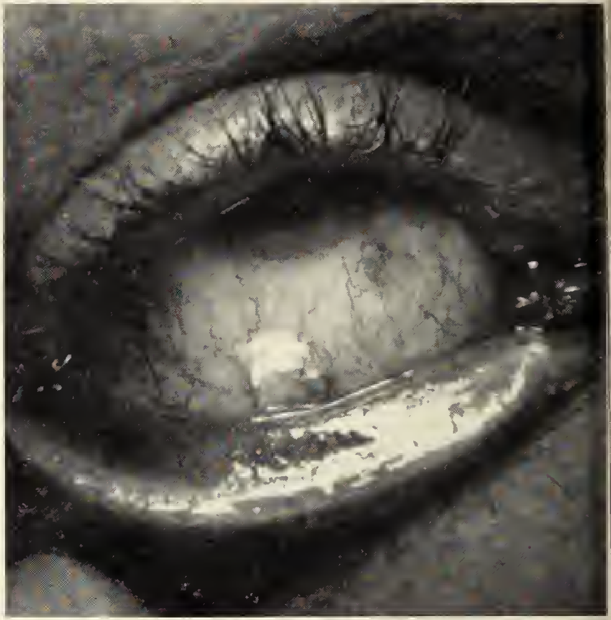

FIGURE 3: Multiple pigment deposits in lower lid of patient receiving epinephrine drugs for secondary glaucoma.

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The 1964 reprints totaled 159,300.

ORIGINAL SCIENTIFIC ARTICLE

iagnosis and Differential Diagnosis f Migraine and Muscle-Contraction Headache

y Arnold P. Friedman, M.D.
ew York City

Clinical descriptions of headache have appeared in ie medical literature for over 2,000 years. Although i the past decade some progress has been made in nderstanding the mechanism, diagnosis, and treatient of headache, particularly migraine, too often igraine or muscle-contraction headache is still not orrectly diagnosed, or the available resources for ffective therapy are not used.

* * *

IT IS PARTICULARLY pertinent to this discusion that 90 per cent of the 15,000 patients admitted o the Montefiore Hospital Headache Unit in the ast 20 years had migraine and muscle-contraction tension) headaches.[1]

MIGRAINE

The diagnosis of migraine is made essentially on he basis of the patient's history and the absence of vidence of intracranial pathology.

Several varieties of vascular headache of the miraine type can be categorized diagnostically as folows:[2]

Classic Migraine. In this type, the headache is eriodic and recurrent; familial and personality facors are of great importance in its pathogenesis. As rule, the prodromes are definite, contralateral neuroogic manifestations, usually visual, but in some cases notor or sensory. The pain is unilateral, of a throbing nature, and lasts four to six hours; in the later tages, the pain often spreads to other parts of the ead. Anorexia, nausea, and vomiting are concomitant eatures. Classic migraine occurs in about 10 per cent f patients.

Common Migraine. The prodromes of common nigraine are vague, and may precede the attack by everal hours or days. They include psychic disturbnces, gastrointestinal manifestations, and changes in luid balance. The actual headache episode lasts many ours to several days. The pain is steady, unilateral, aching, or throbbing. Associated symptoms include nausea, vomiting, fatigue, chills, localized or general edema, and diuresis; nasal signs and symptoms may occur which may lead the physician to ascribe the headache to involvement of nasal structures. This type of migraine is often seen clinically.

Cluster Migraine. The headache occurs in a series of closely spaced attacks, which may be followed by remissions of months or even years. Prodromes are uncommon; the pain may occur suddenly and wake the patient after an hour or two of sleep. Injection of the conjunctiva, tearing, nasal stuffiness, occasionally ptosis and miosis, and sometimes unilateral or bilateral sweating are associated manifestations. The pain stops after 20 to 90 minutes as suddenly as it began. Cluster migraine is most common in older men.

Hemiplegic and Ophthalmoplegic Migraine. This rare type of migraine may occur in the young adult. The pain is moderate, is on the same side as the ophthalmoplegia, and is accompanied by extraocular muscle palsies involving the third cranial nerve (internal as well as external ophthalmoplegia) and other oculomotor nerves. Often, the paralysis occurs as the headache subsides, three to five days after the onset of a persisting headache. The hemiplegic migraine complex is characterized by neurologic deficits, hemiparesis, or even hemiplegia. The neurologic phenomena of both hemiplegic and ophthalmoplegic migraine may persist for some time after the headache has subsided. Frequent ophthalmoplegic attacks may cause permanent injury of the third cranial nerve.

Basilar Artery Migraine. This type has been suggested as still another form.[3] It occurs predominantly in young women (adolescence to 35 years); in over 75 per cent of the patients there is a family history of migraine. The first symptom is usually visual, varying from partial to total loss of sight. This is followed by vertigo, ataxia of gait, dysarthria, and occasionally tinnitus, though not necessarily in that sequence. Sensory manifestations consist of tingling and numbness in the periphery of the extremities, in the lips, and in the tongue. These symptoms last from two to 45 minutes and are usually followed by a severe, throbbing, occipital headache associated with vomiting. Occasionally, the more common classic migraine occurs. Between attacks, the patients are symptom-free, with a feeling of relative well-being. Vertebral angiograms in these patients are normal.

While migraine is usually a benign disorder, it may also be a mask for a serious psychologic disturbance and may affect the person's ability to function. In

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the migrainoid obsessional patient, release of hostility often causes depression; it is important that such depression be differentiated from the more usual types of depression.

* * *

OCCASIONALLY, an attack of migraine precipitates a major or minor cerebrovascular accident, including infarction or thrombosis of cerebral or retinal vessels in the vasoconstrictive phase, or hemorrhage due to rupture or diapedesis of the intra- or extracranial vessels during vasodilatation.

Féré,[4] in 1881, cited Charcot as saying that any of the transient neurological disturbances of migraine could become permanent. Recent arteriographic studies which have excluded the presence of malformations also indicate that migraine may lead to permanent damage of neural structures. Lesions of the retina, the cerebral hemispheres, and the brain stem have been found in patients with migraine who were younger than the usual age for onset of cerebrovascular disease. As a rule, the most frequently affected area is the occipital cortex.

There is a possible relation between migraine and cerebral aneurysms, since 10 to 40 per cent of patients with subarachnoid hemorrhage have a history of migraine and recurrent headaches of many years' standing. Factors which raise the systemic arteriovenous blood pressure during migraine attacks may precipitate an intracranial hemorrhage in the presence of a cerebral aneurysm.

DIFFERENTIAL DIAGNOSIS—CLASSIC AND COMMON MIGRAINE

Classic and common migraine must be differentiated from intracranial lesions which produce headaches simulating those of migraine; these include vascular malformation, aneurysm, and other expanding lesions.

Fear of brain tumor often drives a patient with headache to consult a physician. The development of neurologic symptoms and signs in a headache patient should alert the physician to the possibility of structural etiology. In our experience, neither the site nor the character of the headache can be depended upon in the differential diagnosis or the localization of a intracranial tumor.

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In most cases of posterior fossa tumors, includin angle tumors, headache is a prominent early symptom and is referred to the occipital region and posterio aspect of the neck. An exception to this is intra medullary tumors of the brain stem. Tumors developing within the ventricle may give rise to severe sudden headache when the head is moved to a specifi position. Fulton and Bailey[5] have explained this a the result of the ball-valve action of the tumor. Thi type of headache is most frequently observed in patients with tumors of the third ventricle.

* * *

HEADACHE IS OFTEN an early manifestation of tumors which compress the midbrain, particularly pinealomas. It is due to compression of the aqueduc of Sylvius and increased intracranial pressure. Pituitary neoplasms may produce pressure on the diaphragm sellae and cause headaches accompanied by bitemporal hemianoptic atrophy and sellar alterations The headaches may occur in the early stages, and are then usually mild and remittent.

Later, the patient may complain of retro-orbita pain just above the inner canthi of the eyes. Headache is not necessarily an early sign of supratentoria tumors. Pain arising from intracranial structures above the tentoria is usually referred to the frontotemporal or anteroparietal areas on the same side. With the onset of increased intracranial pressure, the localization of the headache is not significant.

In the early stages of the tumor, headaches may appear irregularly and be of short duration; later, they may occur daily and last for hours. Patients with meningiomas, which are slow-growing tumors, may have headaches for many years before they consult a physician. The headaches may be deep, aching, throbbing, or pressing. They are not necessarily severe; e.g., migraine or headaches associated with subarachnoid hemorrhage and meningitis are generally more intense.

Factors which raise the intracranial or venous pressure (coughing, rectal straining, bending) intensify the headache.

Aneurysms and angiomatous malformations are frequently accompanied by periodic headache which may mimic that of migraine. The characteristics of such a headache may be indistinguishable from migraine, except that it is usually localized *consistently in one area* on the same side of the head. Sudden onset of paralysis of the third or other cranial nerves suggests the presence of an aneurysm. Subarachnoid bleeding may occur in a patient with an aneurysm of angiomatous malformation.

The patient with an angiomatous malformation may have a history of recurrent convulsive seizures, or pre-existing hemiparesis or hemianesthesia, etc., of explained origin; occasionally a bruit may be heard the neighborhood of the malformation.

In older patients, head pain from temporal arteis, carotid and basilar insufficiency, and glaucoma ust be considered in the differential diagnosis.

Temporal Arteritis. Headache which occurs late life (55 to 80 years) for the first time—and which ay resemble migraine—may be due to arteritis. emporal arteritis may be acute or subacute, and is ore prominent in women than in men. The term ay be misleading, as some now consider the lesion be part of a generalized arteritis, possibly involving her vessels, such as the aorta, the ophthalmic artery, nd the internal carotid.

The etiology is unknown, but inflammatory and egenerative histologic changes are found in the vessel all. At the onset of the disease, frequent signs and mptoms are fatigue, fever, weakness, profuse sweatng, generalized headaches, and pain in different parts f the body. Leukocytosis is present and the sedientation rate is increased. The patient's general ppearance is that of an acutely ill person. Local volvement of the vessel may be manifested by severe, robbing pain, and apt to be worse at night. Most ften, the pain is in the temporal region, although the ccipital and parietal areas may be involved. Strainng, coughing, and chewing aggravate the pain.

* * *

EXAMINATION of the affected arteries will freuently reveal them to be swollen, hard, nodular, and ensitive to palpation. In later stages, the artery may ecome a firm, pulseless cord. Photophobia, ptosis, iplopia, and partial loss of vision are often associated ith the head pain. The retinal arteries may reveal rteriosclerosis, hemorrhage, or exudate. These hanges may also be associated with loss of vision. differential diagnosis between temporal arteritis, hromboangiitis obliterans, and periarteritis nodosum s frequently difficult. Biopsy of the involved vessel ill help to establish the diagnosis.

Other types of recurrent headache which can masuerade as migraine include those associated with ypersensitivity or an allergic reaction, hypertension, olycythemia, anxiety states, and depressive states.

Cluster headaches and lower-half headache may simulate allergic headache, headache associated with acute sinusitis, and certain atypical and typical neuralgias.

Various conditions, including intracranial aneurysm, tumors of and about the third cranial nerve, basilar leptomeningitis, diabetes mellitus, and myasthenia gravis may produce signs and symptoms similar to those seen in ophthalmoplegic migraine.

MUSCLE-CONTRACTION (TENSION) HEADACHES

There is an extremely common type of headache which is nonpulsatile, which may go on for days, weeks, or years, and which is usually not intense. Unlike migraine, muscle-contraction headache occurs during the immediate period of tension or anxiety. The ambiguous and unsatisfactory terms, "tension," "psychogenic," and "nervous" headache, refer largely to this group. Such headaches do not have prodromes, are usualy bilateral, occipital, or frontal, are of gradual onset, and may be accompanied by a variety of signs, including anxiety and dizziness.

Patients with tenson headache describe their symptoms as a pressing, a tightness, a generalized head discomfort, or a feeling of wearing a tight cap (hatband type). The frequency and duration of these headaches vary, but commonly they last days or weeks. The headache does not interfere with sleep, but is present when the patient wakes in the morning. A life history of headache is less common than it is in migraine.

Examination reveals muscle contraction, tender spots in the neck and scalp, and in some cases limited movement of the neck. Neurologic signs are absent.

* * *

IN THE DIFFERENTIAL diagnosis, other lesions of the muscles and bones of the upper cervical region must be considered. These include bony anomalies of the occipitocervical junction, basilar invagination, chronic mastoiditis, and malocclusion of the temporomandibular joint. Posterior fossa lesions should be suspected when the headache changes with rapid postural changes or with jarring of the head, or when

Most headaches which the physician treats in office practice can be divided into two main categories, muscle-contraction headaches and vascular headaches of the migraine type.

Several varieties of migraine can be categorized as: classic, common, cluster, and ophthalmoplegic. Muscle-contraction headaches, unlike migraine, occur during the immediate period of anxiety, are usually not intense, and may persist for long periods. Proper attention to the differential diagnosis of chronic headache is important since it may be indicative of an underlying structural disease or of serious psychologic disturbances.

pain is aggravated or brought on by coughing or straining.

The idea that chronic headache is often caused by lesions of the lower cervical spine, particularly with lesions associated with cervical spondylosis and the scalenus anterior muscle, should not be accepted uncritically. No doubt, some patients may have both cervical disk disease and head pain, and surgical procedures on the cervical spine may be followed by clearing of the head pain. However, the relation is far from clear.

It is worth remembering that cervical disk disease is a common roentgenographic feature in persons over the age of 50, and that it is often asymptomatic.

CONCLUSION

In general, migraine and muscle-contraction headaches are a benign condition, although a patient with severe and frequent attacks may be a semi-invalid. There is some evidence that cerebral infarcts, hemorrhage, and permanent neurologic deficit may develop in persons with migraine. Since recurrent headaches may be an ominous sign of an underlying structural disease or of serious psychologic disturbances, an acute awareness of this possibility and proper attention to the differential diagnosis of headache are particularly important.

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The Score: USA 75, USSR 0

That's the score in new drug competition. In 48 years, Russia's government-owned pharmaceutical industry has not developed a single new and important drug, whereas the American pharmaceutical industry in the last 24 years alone has come up with at least 75 new drug entities.

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A donation of land and buildings valued at approximately $330,000 has been given to Bloomfield College by Schering Corporation. The gift consists of 2.44 acres of land and 10 major buildings, an area which since 1959 has housed a large portion of Schering's chemical research department. The gift will "help meet the needs of the school's growing science department."

ORIGINAL SCIENTIFIC ARTICLE

Epidemiological Identification Of Urban Point Sources Of Histoplasmal Infections 1 Two Michigan Communities

y H. J. Dodge, M.D., M.P.H.
tto K. Engelke, M.D., M.P.H.
oth of Ann Arbor

During the early phases of our knowledge of the ›idemiology of human infections by the fungus, *istoplasma capsulatum,* it appeared that these would : of little consequence to lifetime residents of Michan.

The picture of the geographic distribution of the evalence of sensitivity of histoplasmin, gained rough skin test surveys of children and young adults, dicated that prevalence rates were of the order of to 20 per cent in Michigan residents and low by ›mparison with those of the central part of the issisippi River Valley.[1]

* * *

IN ADDITION, IT was part of our concept that e "point sources," or areas of soil in which the ngus grows and from which it is disseminated, were rgely limited to rural locations. For a period of ne, histoplasmosis was regarded as a rural disease that the large majority of recognized infections curred in persons who went to rural point sources d engaged in activities which stirred up dust with burden of spores of the fungus.

In 1961, Furcolow and his associates published a view of the evidence and pointed out what they lled "the emerging pattern of urban histoplasmo-s."[2] Classified as urban sources of infection were posure: (1) to imported farm soils or manures;) in urban structures (such as buildings heavily ›ntaminated with bird droppings); and (3) in open ban areas (away from buildings or sites of imported rm soil or manure), especially those associated with gh density of flocking and roosting of wild birds, e common starling being the most notable species.

It is with regard to the third type of exposure that e wish to report. Our purpose is that of alerting ysicians and public health workers of Michigan to e possibility of other such urban foci of infection d to the serious potentialities of such sites.

The first community came under study following the decision by one of us (O.K.E.) to add histoplasmin testing to the routine of tuberculin testing of school children in Washtenaw County. Some of the physicians practicing in the southern part of the county felt that they were seeing a higher incidence of pulmonary histoplasmosis than the known prevalence of positive histoplasmin tests in area residents would lead them to expect. The results of this trial of histoplasmin testing have been extensively reported.[3-6]

A second community came under study as a result of a program of routine skin testing of naval recruits with histoplasmin, among other antigens.[7] On analysis of the data, it appeared that Clinton County, Michigan, had an excessive prevalence rate of histoplasmin sensitivity by comparison with the remainder of the state. Further analysis suggested that this excessively high rate was contributed largely by recruits who said they had lived all their lives in or near one specific community in that county.

* * *

APART FROM the method of identifying the communities originally as areas for intensive study, the two are so similar in their epidemiologic patterns of histoplasmal infections that they can be described in the same terms. The methods of study were the same. Children attending school in the community made up the study population with children attending school in nearby districts acting as the control or comparison groups; the histoplasmin test was the principal tool and prevlance rates of positive tests the principal index for developing a hypothesis as to the location of the point source; soil samples representing the community and surrounding areas were put through laboratory procedures for recovery and identification of the fungus, as test of the hypothesis.

Chest x-ray films, while of considerable intrinsic interest for evidence of chest pathology, contributed little as an epidemiologic tool.

Both communities are "villages" in terms of their corporate status, and until recently had a single school building each, located centrally in the town. With the development of consolidation, each had become the center of a large school district. Although the communities are small in terms of resident population, they are centers for the aggregation of large numbers of children from the surrounding country.

* * *

IN EACH CASE, THE evidence from skin testing pointed to the environs of the original school build-

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ing as the most likely site of the point source of fungus dissemination; trees in the school yard served as part of a well-defined and long-established starling roost (the only one in town); play equipment (swings, slides, teeter-totters) located in the roost area had long been in use; there were extensive bare earth areas which were productive of dust and mud which could be carried into the school building or busses or about the neighbrohood; the fungus, *H. capsulatum*, was recovered from soil samples from the school ground but only from those taken from the area included by the bounds of the starling roost.

As a result of these findings it is our conception that in these two communities, at least, the problem of histoplasmal infections among school children can best be summarized as a series of relationships as follows: trees—starlings—droppings—soil—fungus—spores—dust—children. This is not to imply that adults are not at risk. We have not tested a representative sample of adults in either community; however, the evidence from those adults we have tested with histoplasmin fits well into the above scheme.

We know of no evidence to suggest that birds can be parasitized by the fungus or that they act as mechanical carriers. Rather it is our view that where birds, or bats, congregate in large numbers in a small area over a long period of time, their feces fertilize the soil in such a way as to give the fungus, *H. capsulatum*, competitive advantage over other soil microorganisms. The fungus flourishes in the soil producing billions of spores some of which get into the air and, if inhaled by a mammalian host, may initiate infection.

* * *

IT SHOULD BE MADE CLEAR that in neither community is there any history to suggest epidemics of the disease histoplasmosis. The evidence strongly suggests that the situation is better described as one of hyperendemic sensitivity to hisoplasmin: while there has been a high incidence of infection over a long span of years, the large majority of infections have not progressed to clinically recognized disease and the only practical evidence of their existence is the residual sensitivity to histoplasmin.

There is, further, no evidence that the fungus r covered is lacking in virulence. Two laboratory work ers handled four soil samples collected from the fir community; within about ten days they develope acute pulmonary histoplasmosis; the fungus was is lated from one of the four soils.[8]

* * *

LEST ANYONE BE disarmed by the apparen benignity of *H. capsulatum* infections in these tw communities, we must stress that the existence of suc point sources holds a serious potential threat to in dividuals and to groups exposed and infected. Inap parent infections may result in lesions which, althoug inactive for long periods of time, may later becom active and progress to disabling or fatal disease. Di turbance of the soil of point sources with the produc tion of much dust in the midst of an urban com munity may lead to serious epidemics.

Examples of this situation are Walworth, Wiscon sin,[9] and Mason City, Iowa.[10,11] In these cities cen trally located point sources were discovered on inve tigations of epidemics of histoplasmosis involving by standers as well as workers who moved earth and cre ated dust at the point source. In Mason City tw separate epidemics occurred. Investigation turne up a total of 115 cases of acute pulmonary histopla mosis; two of these individuals died and five mor progressed to chronic cavitary disease.

As with the two Michigan villages discussed above Walworth and Mason City are located in areas wher the general prevalence of histoplasmin sensitivity of a low order and, in both, point sources were asso ciated with bird roosting sites.

* * *

WE END THIS note with a plea to physician and public health workers to be alert to the poss bility of point sources within their own communitie so that, if such are found, measures can be taken t reduce the risk of infection, disease and death to th people frequenting the community. In the first com munity which we have studied, infection rates hav declined appreciably following the paving or soddin of the bare earth areas of the school yard; thes measures have markedly reduced the opportunitie for spores to escape from the soil in dust. The studie in Mason City indicate that since the application c

Events leading to the discovery of the association of histoplasmosis with birds, shade trees, playgrounds, buses and school children, in two Michigan communities are described in this article. Cooperation of community physicians with the Public Health Department and the University of Michigan School of Public Health in uncovering the cause and developing the remedy for this condition is reported. The possible occurrence of histoplasmosis in areas where it may be least suspected is emphasized.

3 per cent solution of formaldehyde to the point urce, the fungus can no longer be recovered from rface samples of the soil.[11]

ACKNOWLEDGMENT

We are indebted to many individuals and groups official and voluntary agencies, school boards and ffs, parents and children—for their support and rticipation. Particular thanks, however, are due e personnel of the skin testing teams of the Southstern Michigan Tuberculosis Detection Project and the Tuberculosis Program of the U.S. Public alth Service.

These studies were supported, in part, by a Train- Grant (GM-6) from the National Institutes of alth.

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xcellent Guide

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Histoplasmin Survey, Delta County, Michigan

By Mary L. Cretens, M.D.
Gladstone, Mich.

A histoplasmin survey conducted in the high schools of Delta County, Michigan, a rural Upper Peninsula County, revealed a 2.1 per cent student reactor rate with 6 mm or more induration. Details of the program and characteristics of the reactors are described.

This report is based on findings obtained from a histoplasmin testing program conducted by the Delta-Menominee District Health Department in the Delta County Schools in 1965. Ninth, tenth, eleventh, and twelfth grade students were tested.

Delta County, which is located in the western half of the Upper Peninsula, has had no cases of histoplasmosis reported in persons of any age for at least the past 10 years. However, there has been a relatively high number of tuberculosis patients admitted to sanitoria in spite of the basically rural character of Delta County. In years past many of the diagnosed cases of tuberculosis had small or doubtfully positive tuberculin reactions.

The purpose of this testing program was, in the main, to determine the incidence of histoplasmin reactors in the area. No school group surveys for histoplasmin sensitivity had been done in this area previously. Its purpose also was to acquaint residents of the area with the nature of the disease histoplasmosis. The prevalence of histoplasmin reactors is higher in the southern and central part of the Lower Peninsula than in the remainder of the state of Michigan. Because of this it has been anticipated that the incidence of histoplasmin reactors in the Upper Peninsula will increase with continued interchange of residence and travel between the Peninsulas. Another purpose of this survey, and probably the most important, was to demonstrate to the physicians the necessity of considering this disease in patients presenting respiratory symptoms.

MATERIALS AND METHODS

Histoplasmin antigen (Lot 28), furnished by the Michigan Department of Health was administered intracutaneously in the right forearm in a 0.1 cc dose.

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These skin tests were given either by the Health Department physician or nurses employed by the Western Upper Peninsula Tuberculosis Control Project. Tests were read between 48 and 72 hours and doubtful reactors were retested at the Health Department. Primary test results were read by the nursing team working on the project. Doubtful reactors who were retested had their tests read by the Health Department physician. Tests of 6 mm or more induration were considered positive. Students who were read as positive were x-rayed at the Health Department. These x-rays were financed through the local Tuberculosis and Respiratory Disease Association. The x-rays were interpreted by Dr. James Acocks, Tuberculosis Control Officer for the area. Tuberculin tests were given concurrently in the left arm and were read at the same time as the histoplasmin test.

Each reactor's family was interviewed and all family members were encouraged to obtain histoplasmin tests. The information gathered focused around the areas which might point to the source of contact with the fungus causing histoplasmosis and symptoms which might indicate previous overt disease.

RESULTS

A total of 2,262 children of a high school enrollment of 2,831 (approximately 80 per cent) were tested. Forty-seven students had an induration of 6 mm or more on preliminary testing or retesting. (Six millimeters was read as the minimum positive reaction.) The male:female ratio of students is approximately 1:1 in these schools, yet 31 of the student reactors were males and 16 were females.

The students tested ranged from 14 to 18 years with a reactor distribution of four positive reactors at 14 years; 13 at 15 years; 6 at 16 years; 14 at 17 years and 10 at 18 years. The reaction size and the numbers of reactors were as follows: 25 had 6 to 10 mm reactions; 16 had 11 to 15 mm reactions; six had 16 to 30 mm reactions. Of this number 24 lived in the city proper and 23 in an area that would be considered rural. This compares with the general student population distribution in Delta County. No particular area had a disproportionate number of positive reactors. Eleven of the 47 reactors had been outside of the Upper Peninsula of Michigan. Mos of those who had been outside of the Upper Pen insula visited or lived in Southern Wisconsin for period of time.

Most of the students involved had had repeate contact with birds: 24 with chickens; eight wit pigeons; five with parakeets; two with starlings. Te had no known exposure to birds or bird droppings The 47 past medical diagnoses included: pneumonia (five), allergy (two), bronchitis (three), repeated bouts of influenza (two). One of the positiv histoplasmin reactors also had a positive tuberculin X-rays of the reactor group revealed 36 normal film and 11 abnormal films. One film showed cardia enlargement and the other ten revealed calcifie areas in the the lungs and/or increased lung markings.

All members of 20 reactor's families received histoplasmin tests and the other 27 families lacked testing of one or more members. Eleven families ha additional family members who had positive histoplasmin reactions of six or more mm induration.

Included is a summary of the findings:

The Author

MARY L. CRETENS, M.D.

TABULATION OF RESULTS OF POSITIVE HISTOPLASMIN REACTORS GRADES 9 THROUGH 12 IN DELTA COUNTY

Sex—Males	31
Females	16
Size of Indurated Area	
6-10 mm	25
11-15 mm	16
16-30 mm	6
X-ray Findings	
Normal chest	36
Abnormal chest	11
Lung	10
Heart	1
Clinical History	
Pneumonia	5
Bronchitis in past	3
Allergy	2
Repeated flu	2
Exposure to Birds	
Chickens	24
Pidgeons	8
Parakeets	5
Starlings	2
No exposure	10
Place of Residence	
City	24
Rural	23
Lived or visited Outside Area	11

CONCLUSIONS

In the histoplasmin testing program of students grades nine through 12 in the Delta County Schools 2.1 per cent of the students were read as having induration of 6 mm or more. Considering these a positive reactors, this compares with a 1 per cen ositive tuberculin reactor rate over the complete chool enrollment.

This program indicates that there is an opportunity o contract histoplasmosis in this area. It was further bserved that the reactor rate is higher in males and hat contact with birds, especially chickens, pigeons, nd parakeets, seems to be quite high in the reactor roup. This group of students also had had a considerable amount of severe respiratory disease in the ast.

The absence of calcification or abnormality on -ray of 36 of the group is difficult to explain. Two hildren of the 47 had a resolving lung disease at the ime of x-ray, however. Based on the findings in these wo there is a possibility that other positive reactors ill demonstrate areas of calcification on later chest -rays.

Incidentally, it was found that the addition of histoplasmin testing to the reguular tuberculin testing ook little additional time.

SUMMARY

A survey histoplasmin testing program carried out n conjunction with tuberculin testing in grades nine hrough 12 in Delta County, Michigan, revealed 47 ositive reactors out of 2,262 students tested. Indication was given through this program that histoplasmin should be considered in the differential diagnosis of obscure lung disease.

ACKNOWLEDGMENT

Acknowledgment must be given to H. J. Dodge, M.D., School of Public Health, University of Michigan, for help in setting up the histoplasmin testing program details.

Comments from England:

"If the present shortage of doctors continues, as continue it must for some time to come, then the country will be faced with the growing paradox of an increasingly prosperous public working shorter and shorter hours, and a generally less prosperous profession working longer and longer hours.

"If the doctors do not work longer, then they will have to squeeze more work into the existing day by cutting their corners in various ways and by employing ancillary workers, provided these can be secured.

"The more the individual doctor keeps his eye steadfastly fixed on the target of medical excellence and is prepared, when necessary, to withdraw from the state scheme, the more likely it is that reform of the N.H.S. will be achieved. As to the alleviation of the problems created by the present Monolithic system of hospital administration, these may well have to await the appointment of some medical Doctor Beeching.

Quoted from Enoch Powell in the London Daily Telegram.

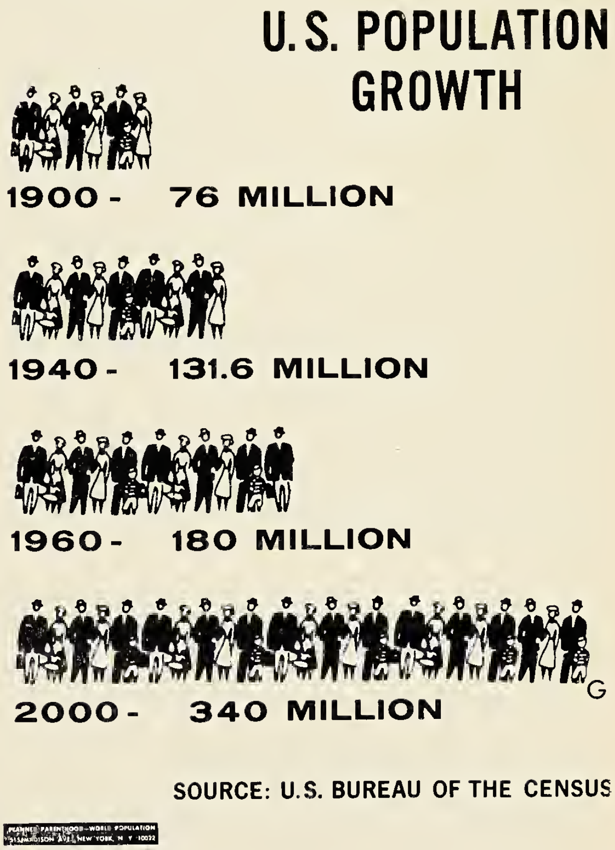
Six Billion Soon Estimated Population

If you're alive 30 years from now, you'll be able to say, "Of all the people who have been born since the year 1 A.D., about half of them are alive today!"

Strange as this seems, the fact remains that by 1995, there will be six billion people on earth if the present rate of population growth continues.

Twice as many people are born as die each year, says Kenneth B. Keating, former U. S. Senator and currently National Chairman of the Population Crisis Committee.

According to a report from the Population Reference Bureau, Inc., in 50 years the population of the United States may reach 500 million—increasing each 10 years by the total number of people in the country in 1900.



The nation's population is growing, but the cost of government is growing faster. Each American's 1965 share of the total (Federal, state and local) tax burden is $853 calculated thus: Federal, $564, state,$156 and local,$133.

ORIGINAL
SCIENTIFIC
ARTICLE

Congenital Malformations With Special Reference To Cysts in the Kidneys

Malformations are due to many causes including abnormal genes or chromosomes, an abnormal environment such as x-ray, certain viruses, chemical agents, hypoxia and so on. The more complex the development of an organ the more commonly it is the site of a malformation. The kidney, for instance, has many malformations including agenesis, abnormal size, shape or location, cysts in collecting tubules, nephrons or both, and congenital tumors.

By Edith L. Potter, M.D.
Chicago

Developing tissues may respond to a noxious agent in many ways, related in part to the agent itself and the time at which it acts, and in part to the environment within which the action takes place. The virus of rubella, for instance, is the only agent known to produce a particular type of cataract, but it produces this only when acting at a specific time and at some other time may produce some other abnormality.

Not all fetuses exposed to the rubella virus react unfavorably, a fact that must be determined by something within the fetus itself.

The effect of a teratogenic agent may be extremely local as in the production of a septal defect in the heart, or it may involve a segment of the body as in the production of the so-called siren monster, or it may involve all of one type of tissue wherever found as in achondroplasia or osteopsathyrosis. One abnormality may lead to another, as in renal agenesis where failure of the ureteral bud to arise from the mesonephric duct leads to failure of differentiation of metanephric blastema.

Many seemingly unrelated abnormalities may be produced, as in Down's disease, where the hands, feet, heart, ears, eyes and so on may be affected in addition to the brain.

* * *

ABNORMALITIES OF FETAL development may be due to many causes, most of which are probably as yet unrecognized. Among the things that are known to be possible teratogens in the human are some viruses and drugs, radiation, variations in chromosome number and the presence of certain genes.

The more complex the manner of organ development, the greater the possibility of disturbance in development. The formation of the heart and the kidneys is more complex and consequently there are more disturbances in development in these organs than in any other.

* * *

EITHER ONE or both ureteral buds may fail to arise from the mesonephric ducts, in which case one or both ureters and kidneys will be absent. Bilateral absence of ureters and kidneys is more common in males, is associated with oligohydramnios, a characteristic facies, bowing of the legs, hypoplasia of the lungs and other abnormalities.

A ureter may be formed, but the metanephric blastema may be missing or fail to respond normally so that a kidney may be absent, hypoplastic or otherwise abnormal even though the ureter is present. Kidneys may be found in abnormal locations and/or may be fused. Disturbances in the intrinsic interaction between the branches of the ureteral bud and the metanephric blastema may give rise to different types of polycystic kidneys.

POLYCYSTIC KIDNEYS ARE OF FOUR PRINCIPAL TYPES

The first variety makes up only a small share of the total number of polycystic kidneys, is usually fatal within a short time of birth, is invariably associated with the presence of cystic bile ducts within the liver and may affect siblings. The kidneys are always enlarged. Branching of ureteral buds and induction of nephrons is normal and the only abnormality consists of hypertrophy of all or most collecting tubules. This variety has been called the cystic kidney of the new born, sponge kidney, hamartomatous kidney and so on.

The second variety is more common than the first

Edith L. Potter, M.D., is a professor in the Department of Obstetrics and Gynecology, The University of Chicago; and pathologist at the Chicago Lying-in Hospital. Address: 5841 Maryland Avenue, Chicago, Illinois 60637.

and more variable in pattern. All or only part of one or both kidneys may be involved. If both kidneys are affected in their entirety, postnatal survival is impossible. When the entire parenchyma of one kidney is affected the condition has been called a multicystic kidney, or if only part of the kidney is involved, it has been called a multilocular cyst. The affected kidney, or the portion affected may be abnormally large or small but development is always abnormal. Collecting tubules branch only a few times and all terminate in cysts; very few nephrons are formed and of these the glomeruli are usually hypoplastic and the tubules are short and abnormal. The liver is usually normal and there is no evidence of inheritance. An affected kidney may be larger than normal at birth but is usually smaller than normal when observed in adult life.

The third variety is usually, but not always, bilateral and is generally, but not always, compatible with an extrauterine existence. Occasionally changes are so severe that the infant dies in the newborn period but they may be sufficiently mild to permit normal renal function throughout life. Bile ducts are cystic in a small percentage and in some cases the renal abnormality appears to be genetically transmitted. This is the condition generally designated as polycystic kidneys.

At birth such kidneys may not be appreciably enlarged but the size becomes gradually increased throughout life as a result of an increase in the amount of fluid in the cysts. Characteristically, there is an intermixture of normal and abnormal structures. Collecting tubules may show either a reduction or increase in the numbers of branches and may be of normal caliber or may be the site of circumscribed or diffuse enlargement or cyst formation. Nephrons may be diffusely enlarged or may have circumscribed cysts in any part of the convoluted tubules or loop of Henle or Bowman's space. Neither in this variety nor in any other is there any evidence that cysts and tubules are discontinuous. Cystic kidneys appear never to be (1) a result of failure of nephrons and collecting tubules to unite, or (2) cystic structures which are normal in the embryo but which become enlarged because of failure of normal regression.

The fourth type of cystic kidney is caused by interference with outflow of urine through the urethra during fetal life. There is no evidence of inheritance and the liver is never affected. The degree of abnormality is related to the time in development when the obstruction occurs and to the extent of the urethral closure. If it occurs early and is fairly complete, many cysts may be present in the parenchyma. They are usually limited to nephrons and Bowman's capsules. Occasionally the renal pelvis is also dilated but often this is not appreciably increased in size even though many nephrons are cystic. Occasionally this is so severe as to cause death in the newborn period, but generally it is more mild and if the obstruction is relieved soon after birth kidney function may be normal.

* * *

ONE OTHER abnormality of development is characterized by failure of certain portions of the metanephrogenic blastema to mature into tubules, glomeruli or normal connective tissue. Such areas are ordinarily designated as Wilms' tumors. In very young infants, particularly in those cases where an actual tumor is present at birth, the stromagenic portion of the blastema is most often involved and in such cases the tumors are generally benign. Small areas of abnormal immature nephrogenic tissue may be an accidental finding in routine examination of kidneys from autopsies on newborn infants, and on rare occasions a large share of the parenchyma immediately under the capsule may be abnormal. Whether such areas would progress into Wilms' tumors is unknown.

The Author
E. L. POTTER, M.D.

In 1873 MSMS Worked For State Health Plan

The work of the Michigan State Medical Society was singled out in a book "Rural Michigan" written by L. Allen Chase and published in 1922 by the MacMillan Company of New York.

In a chapter about "Rural Living Conditions," the author made some comments about the founding of MSMS.

In part, author Chase wrote:

"Public provision in relation to health was not organized for many years. Physicians were few and miles apart. The "beat" of Thomas Phillips of Oceana County extended for fifty miles along the Lake Michigan shore, and was covered on foot, when need was. Patients received much more time for less fee than now.

"In 1873, under the impetus of the state medical society, came the establishment of the State Board of Health, with an initial appropriation of $4,000. Coincidentally, the state inspectorship of oils was designed to protect the public against the highly inflammable brands of kerosene then on the market. Shortly the State Board of Health was familiarizing the general public with sanitary principles through the medium of sanitary conventions."

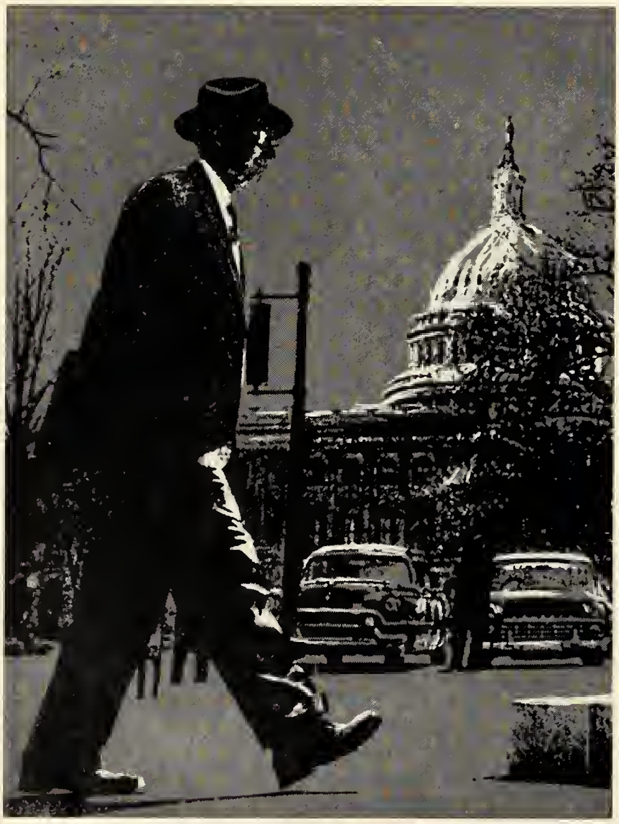
Election Calendar; Get Busy Now

Appeals that physicians be more concerned with political affairs and good government are made frequently — and the elections in November certainly point up the opportunities here.

Michigan voters on November 8 will select a new Governor, Lieutenant Governor, all state Representatives and Senators, two members of the State Board of Education, two members of the MSU Board of Trustees, two members of the U-M Board of Regents, two members of WSU Board of Governors, two members of the Michigan Supreme Court, Secretary of State, Attorney General, one U. S. Senator, and 19 U. S. Representatives.

The following calendar will be of interest to physicians and county medical societies that are concerned about precinct activity, about the continuous need for good candidates, about the need for voter registration, etc.

May 24 — Last day for candidates for precinct delegates to the county convention of each political party to file nominating petitions.



June 3 — Last date for the State Central Committee of each political party to issue the call for the Fall State Convention of such political party.

June 11 — The last date for candidates for file fees to qualify for filing nominating petitions.

June 14 — Last date for partisan and non-partisan candidates to file nominating petitions.

June 18 — Last date for the State Central Committee of each political party to issue the call for county conventions.

July 5 — Last date to register for the primary election. Places for registration are to be open between 8 a.m. and 8 p.m.

July 11 — Last date for filing of petitions by qualified and registered electors proposing an amendment to the State Constitution. Such petitions are to be filed with the Secretary of State.

July 30 — Deadline for absentee ballot applications for the primary election. Such applications must be made by 2:00 p.m.

August 2 — General Primary Election of all political parties.

August 10-21 — County conventions of all political parties will be held between these dates for the nomination of state officers.

September 3 — Last date for holding the State Conventions of all political parties for the nomination of candidates for state offices.

September 6 — Last day for filing of petitions to place local or county questions on the ballot at the general election.

September 20 — Last day to certify the ballot wording of local and county propositions to local or county clerks.

October 10 — The last date to register for the general election. Places of registration shall be open for registration between 8 a.m. and 8 p.m.

November 5 — Deadline for absentee ballot applications for the general election. Such applications must be made by 2 p.m.

November 8 — General November Election.

List Present Members Of Registration Board

The Michigan Board of Registration in Medicine is now composed of the following 10 physicians, with Dr. Kurtz as the chairman and Dr. Harris as vice-chairman:

Terms Expire September 30, 1967: Frederick C. Sabin, M.D., Marquette; C. Allen Payne, M.D., Grand Rapids; Gilbert G. Saltonstall, M.D., Charlevoix; Donald McLean, M.D., Detroit.

Terms Expire September 30, 1969: Irvin J. Kurtz, M.D., Detroit; Bradley M. Harris, M.D., Ypsilanti; Howard H. McNeill, M.D., Pontiac; John J. Coury, M.D., Port Huron; Frederick W. Van Duyne, M.D., Flint; H. Clay Tellman, M.D., Muskegon.

ealthmobile ided by Sears oundation

“The Sears-Roebuck Foundation
honored and very pleased that the
ichigan State Medical Society and
e Michigan Health Council in-
ed them to share in the develop-
ent of the Centennial Healthmo-
e. This is the most exciting and
ique project that our foundation
s assisted in many years.”

So stated Mr. Rembrandt Hiller,
, of Chicago, Vice-President of
ars-Roebuck Foundation and Di-
ctor of Public Relations for the
ars-Roebuck Company.

Mr. Hiller and other Sears-Roe-
ck Foundation officials came to
ichigan on February 11 to see the
ealthmobile while it was on dis-
ay in Port Huron. At a special
ncheon preceding the tour, Mr.
ller was presented with a Health
uncil membership plaque by Rich-
d U. Byerrum, Ph.D., East Lan-
g, President of the Michigan
ealth Council, in recognition of the
0,000 grant made to the Council
the development of the interior
d exhibits of the Healthmobile.
ugh W. Brenneman, MSMS Ex-
utive Director and Secretary of the
ichigan Health Council, served as
airman. Among the guests were
hn J. Coury, M.D., MSMS Coun-
or, Robert E. Rowe, M.D., Presi-
nt of the St. Clair County Medi-
l Society, and Mrs. James H. Tis-
l, President of the Auxiliary.

Donald L. Cudworth, of Chicago,
d Donald Bunting, of Lansing,
esented the Sears-Roebuck Foun-
tion’s $10,000 check at Lansing
February 9. Harold H. Hiscock,
.D., Chairman of The Council of
e Michigan State Medical Society,
ned Dr. Byerrum in expressing
ecial appreciation to the Founda-
n.

MICHIGAN CONFERENCE ON MATERNAL AND PERINATAL WELFARE MARCH 24-25

Deep appreciation to the Sears-Roebuck Foundation for a $10,000 grant toward the cost of developing the MSMS Centennial Healthmobile was voiced by MSMS and Michigan Health Council officials. Left to right at the ceremony were Richard U. Byerrum, Ph.D., MSU, MHC president; Harold H. Hiscock, M.D., Flint, chairman of the MSMS Council; Donald L. Cudworth, Foundation representative from Chicago, and Donald L. Bunting, Foundation representative from Lansing.

Time Soon for PAK Project

The week of March 20-26 will be “National Poison Prevention Week” and an ideal time for physicians to remind their patients with young children about the availability of the Poison Antidote Kit (PAK) from Michigan pharmacists.

The 1965 MSMS House of Delegates adopted Resolution 13 which endorsed the PAK project and urged all physicians to cooperate in this interprofessional effort with the pharmacists.

The kit consists of a plastic box which contains 15 cc Syrup of Ipecac, U.S.P., and 5 gm activated charcoal. The label on the Ipecac tells the parent that “Before using, call physician, the Poison Control Center or hospital emergency room immediately for advice.”

At the recent annual meeting of the Michigan MD-PAC, the officers were re-elected. Continuing as chairman is W. C. C. Cole, Jr., M.D., left, of Detroit, and renamed secretary-treasurer was Vernon V. Bass, M.D., Saginaw. Ambitious plans were outlined for the year.

GP Clinic Soon

The 20th Annual Postgraduate Clinic of the Michigan and Wayne County Academies of General Practice, in Detroit, March 9-10, will offer medical authorities from Oregon, New York, Louisiana, Indiana, Ontario, Ohio, Pennsylvania, California, Massachusetts, Iowa, Illinois, New York and Michigan. Featured will be eight wet clinics, or instruction-in-depth, all directed by recognized authorities, with patients furnished by the V.H.A.

Rep. Gerald R. Ford, of Grand Rapids, will speak at the banquet March 9.

The clinic will be acceptable for 11 accredited hours by A.A.G.P.

PG Programs Set for 18 Cities

The Spring series of MSMS Postgraduate programs—including more afternoon hospital clinical discussions than ever before—has been scheduled by the MSMS Committee on Postgraduate Medical Education.

"The hospital clinical aspects of the educational program have been well received and will be expanded this spring," declares Harry A. Towsley, M.D., Ann Arbor, Committee chairman.

MSMS members in the 18 communities to be served this spring are urged to participate. Once again, distinguished members of the schools of medicine at Wayne State University and the University of Michigan will travel into the state.

In 1964, the Spring programs drew 39.5 per cent of the physicians in the areas served and the 1965 attendance jumped to 47.4 per cent. The 1965 fall attendance at 20 centers hit 55.4 per cent of the potential.

Printed programs with details will be mailed to the physicians in the areas to be served, Doctor Towsley reports.

Following is information about the 1966 spring postgraduate activities in Michigan, indicating the names of the speakers for each program:

Alpena, April 20 (Clinic, Dinne Program)
George H. Lowrey, M.D.; Ea F. Wolfman, M.D.

Battle Creek, May 3 (Dinne Program)
Joe D. Morris, M.D.; Ralph Brandt, M.D.

Cadillac, May 6 (Clinic, Dinne Program)
David G. Dickinson, M.D.; Ge ald A. O'Connor, M.D.

Grayling, April 28 (Clinic, Di ner, Program)
Robert J. Bolt, M.D.; Norma W. Thompson, M.D.

Lansing, May 17 (Dinner, Pr gram)
Ralph L. Brandt, M.D.

Midland, May 12 (Clinic, Dinne Program)
A. James French, M.D.; Fre Hodges, M.D. (Clinic partic pants to also include Carl Badgley, M.D., Arthur C. Cu tis, M.D., F. Bruce Fralic M.D., Reed M. Nesbit, M.D John M. Sheldon, M.D., Ea F. Wolfman, Jr., M.D., an Walter P. Work, M.D.)

(Continued on Page 199)

Judicial Commission Organizes

The new Judicial Commission, elected in accordance with directives of the 1965 House of Delegates, has held its first meeting and selected Donald N. Sweeny, Jr., M.D., Detroit, as its first Chairman.

Harold A. Furlong, M.D., Pontiac, was chosen Vice Chairman, and Carl B. Beeman, M.D., Grand Rapids, Secretary. The 10 judicial commissioners drew for terms of office (see identification material under the photograph for this information).

The Commission will have general jurisdiction in matters relating to professional ethics, grievances, mediation, discipline and professional conduct of members.

Left to right are the members of the MSMS Judicial Commission: Sherman E. Andrews, M.D., Kalamazoo (1967); H. Maxwell Golden, M.D., Flint (1966); Carl B. Beeman, M.D., Grand Rapids (1966); Reader J. Hubbell, M.D., Traverse City (1967); Harold A. Furlong, M.D., Pontiac (1968); Norman F. Miller, M.D., Ann Arbor (1968); Hugh M. Fuller, M.D., Detroit (1968); Donald N. Sweeny, Jr., M.D., Detroit (1968); Louis J. Bailey, M.D., Southfield (1966); and Wyman C. C. Cole, Sr., M.D., Detroit (1967). The men drew by lots to decide their terms of office.

(PG Continued)

Muskegon, May 18 (Clinic participants, Tommy N. Evans, M.D., Alexander J. Walt, M.D., and Lawrence Power, M.D.)

Niles, May 17 (Dinner, Program)
Robert W. Sweet, M.D.

Petoskey, May 12 (Clinic, Dinner, Program)
Isadore Lampe, M.D., A. Martin Lerner, M.D.

Port Huron, May 10 (Clinic, Dinner, Program)
Richard C. Schneider, M.D. (Clinic participants, Thomas A. Bruce, M.D., George H. Lowrey, M.D., Richard Schneider, M.D., William S. Smith, M.D., Alexander C. Walt, M.D.)

UPPER PENINSULA

Escanaba, May 17 (Clinic, Dinner, Program)
David G. Dickinson, M.D., George E. LaCroix, M.D.

Houghton, May 17 (Clinic, Dinner, Program)
Robert J. Bolt, M.D., Norman W. Thompson, M.D.

Iron Mountain, May 18 (Clinic, Dinner, Program)
Robert J. Bolt, M.D., Norman W. Thompson, M.D.

Ironwood, May 17 (Clinic, Dinner, Program)
Robert J. Bolt, M.D., Norman W. Thompson, M.D.

Manistique, May 17 (Luncheon, Program)
David G. Dickinson, M.D., George E. LaCroix, M.D.

Marquette, May 19 (Clinic, Dinner, Program)
Robert J. Bolt, M.D., Norman W. Thompson, M.D. (Clinical participants, Robert J. Bolt, M.D., David G. Dickinson, M.D., George E. LaCroix, M.D., Norman W. Thompson, M.D.)

Menominee, May 18 (Clinic, Program)
David G. Dickinson, M.D., George E. LaCroix, M.D.

Sault Ste. Marie, May 16 (Clinic, Dinner, Program)
David G. Dickinson, M.D., George E. LaCroix, M.D.

Healthmobile Makes Stop At Marlette

A special visit was made by the Healthmobile to Marlette during February 18-25 to help say "thank you" to the Marlette Coach Company, who built the mobile unit to specifications and then loaned it to MSMS.

The health-museum-on-wheels was at the Marlette Community Hospital, and was viewed by many teachers, children, families, and workmen of the coach company.

The Healthmobile continues to roll every week into a new Michigan community, each time sponsored by the county medical society and its woman's auxiliary. First shown in Lansing, October 15-22, the unit now has appeared at Flint, Pontiac, Jackson, Battle Creek, Coldwater, Hastings, Ann Arbor, Adrian, Detroit, Roseville, Warren, Port Huron and then Marlette.

The response in Wayne County was so good at Northland Shopping Center in January, that it was rerouted back into Wayne County for February 25-March 4 at Lincoln Park.

Flint Ready for MSMS Maternal Welfare Meet

Addresses, discussions and exhibits will attract many MSMS members to the Michigan Conference on Maternal and Perinatal Welfare at Flint, March 24-25. The fifth annual conference, sponsored by MSMS, will be held at the Pick-Durant Hotel.

There will be no registration fee, only cost for transportation, meals and lodging, points out Wm. W. Jack, M.D., Chairman of the MSMS Maternal Health Committee.

Posters have been placed in hospitals, and programs listing the noted speakers, and vital topics have been mailed to every MSMS member.

Considerable interest has been shown already in the address March 24 by M. Edward Davis, M.D., Chicago, on "The Helpless Baby." Doctor Davis, chief of service, Chicago Lying-In Hospital, is chairman of the University of Chicago department of obstetrics and gynecology.

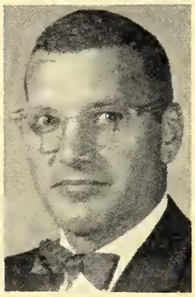
Michigan physicians will be interested in a "Bootie-Hill" exhibit by Lee B. Stevenson, M.D., chairman of the Subcommittee on Perinatal Morbidity and Mortality.

Mrs. F. Ross Burkhill, president of the Woman's Auxiliary to the Wayne County Medical Society, shows Superintendent John English of the Southfield Schools, the Healthmobile exhibits. The Wayne Auxiliary provided wives as Healthmobile hostesses for two weeks, at Northland and at Lincoln Park.

Members of the MSMS Legal Affairs Committee are pictured reviewing for new legislation concerning licensing of hospitals and related facilities. At this particular meeting at the MSMS Headquarters, Committee members discussed issues involved with spokesmen for the Michigan Department of Public Healt
Gov. Romney's "Action Committee on Health Care," and t
Michigan Hospital Association. A single legislative propos
about hospital licensure is being sought upon which all maj
health groups can agree.

Council Re-Elects Hyland, Wiley; Names New Editor

George H. Lowrey, M.D., professor of pediatrics at the University of Michigan Medical School, is the new editor of MICHIGAN MEDICINE. The Council on February 2, voted the appointment upon the recommendation of the Publication Committee. Doctor Lowrey, on the faculty at Ann Arbor for 20 years and an authority on poison prevention, succeeds C. J. Tupper, M.D., who left his position as U-M associate dean of medicine to become dean, on February 1, of the new four-year school of medicine of the University of California at Davis.



LOWREY

Re-elected by the Council were D. Bruce Wiley, M.D., Utica, as secretary; William A. Hyland, M.D., Grand Rapids, as treasurer; Hugh W. Brenneman, East Lansing, as executive director, and Warren F. Tryloff, East Lansing, as associate executive director.

1966 ANNUAL SESSION
GRAND RAPIDS
SEPTEMBER 25-30

MSMS Representative To Governmental Agencies Named

The appointment of Herbert Mehler as staff representative for the Michigan State Medical Society to governmental agencies is announced by Harold H. Hiscock, M.D., Flint, Chairman of the Medical Society Council.

Mr. Mehler, who is presently serving as secretary of the Michigan Workmen's Compensation Department, assumed his new duties February 16.

Mr. Mehler has more than 25 years of public service as a former deputy and chief deputy county clerk for Calhoun County, as a former congressional assistant in Washington, and as a secretary now to an important state department. Mr. Mehler is a veteran of World War II.

Honor McLean

DETROIT — Don W. McLea
M.D., member of The MSMS Cou
cil and a past-president of the Way
County Medical Society, has bee
honored by the Wayne State Unive
sity Fund with its "Distinguishe
Leadership Award." While chai
man of the Fund in 1965, the Fun
set a record of $125,000 in alum
annual giving.

A. John Neerkin, M.D., right, Kalamazo
received an award from the Kalamazo
Red Cross for his efforts in saving th
life of a 16-year-old Kalamazoo boy, wh
fell through thin ice on Woods Lake. Th
award was made by Robert Wollam, Re
Cross official, at a Kalamazoo Academ
of Medicine meeting.

VE MUST INFORM

y C. Joseph Stetler, President,*
armaceutical Manufacturers Association

"Medicine and the drug industry must stride pur-
sefully forward, over the threshold, leading the
blic policymakers by earned right; not blocking
e doorway while they push past in frustration
d ignorance."

If we devote an imbalance of our time simply to
otestations against federal inroads on initiative,
thout earning our credentials by constantly in-
easing the excellence of our private and competi-
e endeavors, then I believe we stand on the thresh-
d of our challenge with our backs to the entrance,
ther than the exit.

While the Federal Government today has broader
wers than ever over the drug industry, it is still
thin the privacy of these enterprises to make two
portant decisions—whether to undertake labora-
ry research on a given project, and what to charge
r a product.

In these terms, the challenge to the pharmaceuti-
l industry becomes rather clear. It is to encourage
blic policies which will at least permit the remain-
g prerogatives to stay in our hands.

* * *

WE CANNOT PREDICT that medicine and
ugs can go on indefinitely adding a decade of
ngevity for every quarter century of research.
eath is inevitable sometime and so is disease. What
ugs can do, however, is change the cause of death
d the conditions under which people live or die.
rugs will continue to lengthen lives, but more im-
rtant, they will make these lives more productive
d useful, and will lessen mental and physical suf-
ring. I know that the committees of the Michigan
ate Medical Society seek to do just that also.

There is widespread recognition that science has
deed fashioned the means to extend life and tamper
th it before birth.

The boundaries of the layman's curiosity are be-
ming as remote as the limits of the scientist's
hievements. The limitations of medical science do
t suggest the question of whether something can
accomplished but rather questions of how and
hen.

How and when, not whether, science can lick the
compatibilities of organ transplants.

How and when, not whether, science can precondi-
n a body against diabetes or cure, not palliate, its
thritis.

How and when a portable machine can replace a heart and a chemical can cure, not ameliorate, a diseased mind.

How many and when, not whether, viruses will yield to an array of effective vaccines.

* * *

IN GENERALITIES and specifics the scientific landscape is strewn with enough indicators to pursue this list indefinitely. But to do so would be to neglect the concomitant factor of the layman's curiosity. It is in this area that I want to defend a syllogism: Lay support of scientific progress is essential. An uninformed laity will be a deterrent to progress.

Citizens can make wise decisions regarding legislation, elections, et al., only if they have adequate and factual knowledge.

It, therefore, is a responsibility of medicine, the drug industry and all of science to inform.

A SNEAKY DOUBLE CROSSER

By Dean P. Carron, M.D.
Ann Arbor

"Millions Spent For Control of Narcotics." "Marijuana—the Trap of the Teen-agers." "Do We Control Paregoric or Does It Control Us?" Do these titles sound familiar? If they do not, certainly the drugs that are referred to are recognized common enemies. But those are pikers! Let me introduce you to a sneaky double crosser —meet the Amphetamines.

Are there legitimate uses for Amphetamines? Sure there are—as a mild stimulant or a corrective, when other medications with sedative side effects, such as anticonvulsants, must be used; as a specific medicine in narcolepsy, a very rare condition; and as part of the medical regimen for treatment of significant hypotension.

What are some of the "illegitimate" uses of Amphetamines? Usually in conjunction with a barbiturate, the drug is used as a general pick-

(Continued on Page 205)

---

*Mr. Stetler was a featured speaker at the MSMS Cen-
nial Session, and made many of these same points there.

in diarrhea

associated with
Gastroenteritis
Spastic bowel
Influenza-like Infections
Antibiotic administration

normal activity...

promptly...

In children with diarrhea prompt symptomatic control is usually urgently indicated to relieve cramping and to prevent dehydration.

Lomotil halts precipitous progress through the intestines and controls diarrhea with notable promptness, safety and effectiveness.

Experimental evidence[1] has shown that Lomotil is more efficient in this regard than morphine without the latter's manifest disadvantages. In roentgenographic study[2] Lomotil slowed gastrointestinal propulsion within two hours.

At the same time, by diminishing overstimulation of the intestines, Lomotil relieves the abdominal cramps and discomfort so distressing to youngsters.

Lomotil gets children off toast and tea and back to normal diets and normal activity with gratifying celerity.

with LOMOTIL® liquid/tablets

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ....2.5 mg.
(Warning: may be habit forming)
atropine sulfate ....0.025 mg.

Dosage: For full therapeutic effect—Rx full therapeutic dosage. The recommended initial *daily dosages,* given in divided doses, until diarrhea is controlled, are:

Children:
3 to 6 months—3 mg. (½ tsp.* t.i.d.)
6 to 12 months—4 mg. (½ tsp. q.i.d.)
1 to 2 years—5 mg. (½ tsp. 5 times daily)
2 to 5 years—6 mg. (1 tsp. t.i.d.)
5 to 8 years—8 mg. (1 tsp. q.i.d.)
8 to 12 years—10 mg. (1 tsp. 5 times daily)

Adults: 20 mg. (2 tsp. 5 times daily or 2 tablets 4 times daily)

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one fourth the therapeutic dose.

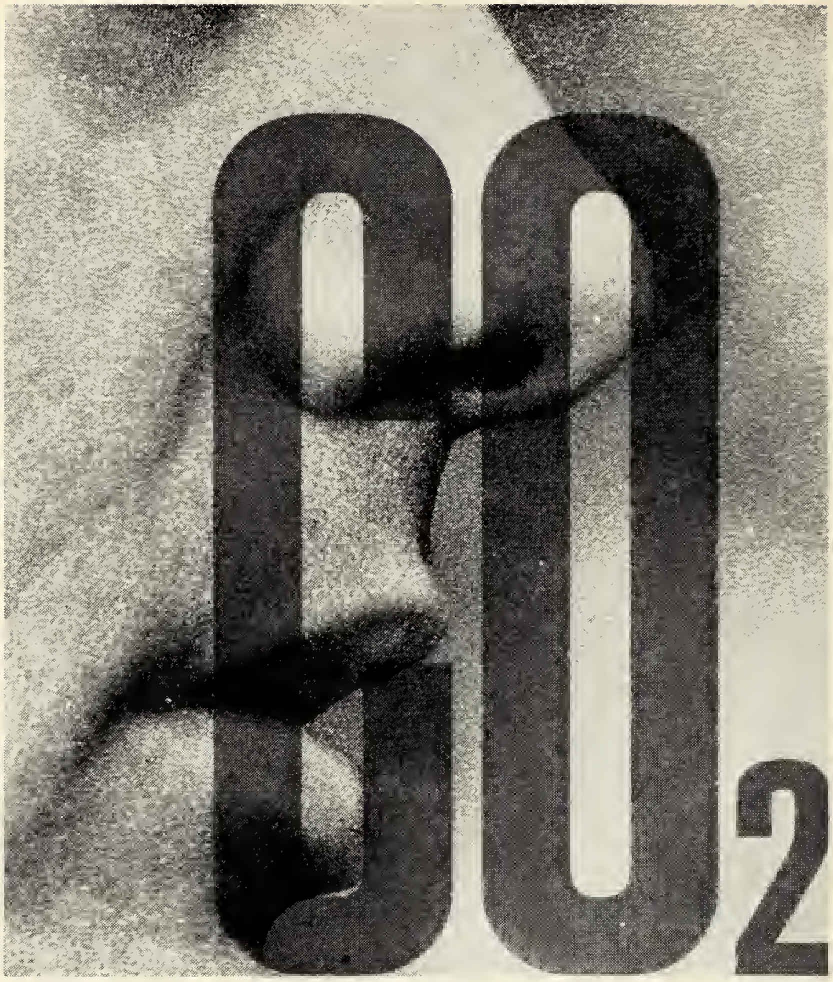
Precautions: Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is an exempt narcotic preparation of very low addictive potential. Recommended dosages should not be exceeded. Lomotil should be used with caution in patients with impaired liver function and in patients taking addicting drugs or barbiturates. The subtherapeutic amount of atropine is added to discourage deliberate overdosage.

Side Effects: Side effects are relatively uncommon but among those reported are gastrointestinal irritation, sedation, dizziness, cutaneous manifestations, restlessness and insomnia.

1. Janssen, P. A. J., and Jageneau, A. H.: A New Series of Potent Analgesics: Dextro 2:2-Diphenyl-3-Methyl-4-Morpholinobutyryl-pyrrolidine and Related Amides. Part 1: Chemical Structure and Pharmacological Activity, J. Pharm. Pharmacol. 9:381-400 (June) 1957.
2. Demeulenaere, L.: Action du R 1132 sur le transit gastro-intestinal, Acta Gastroent. Belg. *21*:674-680 (Sept.-Oct.) 1958.

SEARLE

Research in the Service of Medicine



for patients behind the CO_2 curtain

The lethargic hypoventilators
Hypoventilators may be drowsy and lethargic when they must be awake and alert. The reason: retention of excess CO_2 in the alveoli and blood caused by impaired ventilation with respiratory depression. Most frequent hypoventilators are patients with pulmonary emphysema, extreme obesity, chest cage abnormalities, or cardiopulmonary disease.

EMIVAN helps overcome symptoms of CO_2 depression
Emivan increases depth of breathing and rate, when depressed, so that the lungs "blow off" excess CO_2, and oxygen tension is restored toward normal. As the CO_2 tension falls, symptoms of lethargy, somnolence, fatigue, and irritability abate. Emivan is safe to use: side effects have rarely been observed with oral Emivan (although with overdosage, it may sometimes cause wakefulness); there has been no evidence of toxicity.

Side Effect: Wakefulness at night which responds to reduction in dosage. *Precautions:* Emivan is a ventilatory adjunct to other therapeutic measures; its effectiveness is dependent upon an unobstructed airway. Courses of administration should not exceed eight weeks at a time. An apparent additive stimulant effect between Emivan and MAO inhibitors necessitates adjustment of dosage of either or both drugs when one is used in the presence of the other. *Contraindication:* Known or suspected epilepsy.

Consult product brochure for dosage and full information.
Available: 60 mg. tablets for oral administration; bottles of 100. Also 20 mg. tablets, bottles of 100.

Oral respiratory stimulant for hypoventilators **Emivan®**
brand of Ethamivan

U. S. VITAMIN & PHARMACEUTICAL CORPORATION 800 Second Avenue, New York, N.Y. 10017

e-up. ("I'm so tired in the morning, doctor; if only had something to help me get started.")

Sometimes it is used as an appetite depressant. "I just can't do it myself, doctor; if I only had mething that would help me lose weight.")

It is even used as an excuse for a complete edical work-up. ("I've been feeling so dragged-ut, doctor. Isn't there something that will help e get through the day?")

How many more uses of Amphetamines have een suggested to you?

Am I talking about illicit acquisition of Am-hetamines from black market or under-the-unter sources? No! I am talking about obtain-g prescriptions from licensed physicians.

Your patients know, or soon learn, what these rugs can do for them. They feel more alert, nfident, awake. But oh, such a let down when e pill wears off! ("I can't let that happen—it's o awful. Well, I don't have to feel that way. here is that bottle of pills? Here it is; that's etter . . . bring on those Lions.")

Unfortunately we tend to become resistant to mphetamines fairly rapidly. One tablet, B.I.D. –"a mere nothing." One tablet T.I.D.—"I'm a ttle busier now and need more for just a little hile." Two tablets T.I.D.—"those pills are etting weaker." Two tablets Q.I.D.—"I know hat I need, doc. I can handle this. I just need nother 100 and then I can lick it." And on and n.

What are the late effects of this pattern? In-reased irritability, false bravado, and judgments ased on exaggerated feelings (very "con-enient" when the light is about to change from reen to red), and later on a mental illness very uggestive of paranoid schizophrenia. Too bad, ou say, a mental illness with paranoid delusions; ell remove the drug and this will go away. Not with Amphetamines. Other drugs cause toxic tates and when these are removed or reduced the xic psychosis clears up.

Remove the Amphetamines and what happens the paranoid psychosis? Very often nothing. o, into the hospital, special medications, special reatments, lost earning time and time away from e family for the hapless victim.

Amphetamines become a medical problem when improperly used. It is the doctor's responsibility to use tight control over his prescription refills. It is the doctor's responsibility to familiarize himself with newer and better ways to help start weight reduction or alleviate depression. Most often the doctor doesn't realize that he is playing with potential fire and is ordering a sneaky double-crosser of a drug.

PROFIT AND LOSS

Public service drugs, various examples of which are produced by all major pharmaceutical manufacturers, often are taken for granted by the medical profession and by the public. This class of drugs is distinguished by high production costs, limited market potential, little or no profit, or even loss, and an extremely high value as therapeutic agents, in spite of usage on comparatively rare occasions.

Currently, the Eli Lilly Company is distributing explanatory literature concerning pre-exposure rabies immunization programs to county and state medical society officers and to editors of medical journals.

Lilly's research work in establishing the immunologic principles for pre-exposure immunization against rabies in high risk groups, and their change in packaging which makes the use of their vaccine for this purpose more economical, deserves commendation.

Also deserving of mention is the fact that while economic profit is not to be had from this type of activity, the profit to mankind in general and to both the pharmaceutical and medical profession in particular is great and the contribution praiseworthy.

VOLUNTARY WAY

"Too frequently our national leaders refer to statements indicating that a government should do all the things that the individual can't do for himself or can't do as effectively for himself. These leaders completely overlook the fact that the principal means of accomplishing things in America is through this tool of voluntary cooperation, through free individuals organizing to do things that are too large and difficult for the individual to do. After all, the voluntary basis is more flexible. It adapts itself easier, it's quicker, it's more effective. It can be focused on the point of problem. It can create a power and an influence that can't quite be created through the more ponderous processes of government service."

—George Romney
Governor of Michigan
In MAP Monitor
Vol. II, No. 7

First aid for a button popper

Second aid for a button popper

TURN
30
4867-13
Lederle
BAMADEX®
DEXTRO-AMPHETAMINE SULFATE
WITH MEPROBAMATE
SEQUELS®
Sustained Release Capsules
077-619
LEDERLE LABORATORIES DIVISION

providing combined anorexigenic-tranquilizing action,
MADEX SEQUELS Capsules help your nonshrinking
tients to establish new patterns of eating less. The am-
etamine component suppresses the appetite, while the
probamate helps allay nervousness and tension. And for
st patients, the *sustained* release of the active ingredients
vides convenient one-capsule-a-day dosage.

Side Effects commonly associated with either compo-
nt are possible but, to the extent these are dose-related,
y should normally be mild and infrequent, since the
al dosage of each component on the usual one-capsule-
ily regimen is quite low. Also, the sedating effect of
probamate and the stimulating effect of d-amphetamine
fate tend, to some extent, to cancel each other out. Ad-
rse effects not peculiar to either component have not
en reported. Side effects associated with d-amphetamine
fate include: insomnia, excitability, increased motor
ivity, confusion, anxiety, aggressiveness, increased li-
do, hallucinations, rebound fatigue, depression, dry
uth, anorexia, nausea, vomiting, diarrhea and increased
rdiovascular reactivity. Effects associated with meprobamate include: skin rash, nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema, fever and transient leukopenia; also, very rarely, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, stomatitis, proctitis and anaphylaxis. Other serious effects have occurred after concomitant administration of meprobamate and other drugs. Massive overdosage may produce grave effects.

Precautions: BAMADEX SEQUELS should be given only under close supervision to patients hypersensitive to sympathomimetic drugs, with cardiovascular or coronary disease or who are severely hypertensive; to emotionally unstable persons and to epileptics. Patients should be cautioned not to drink alcoholic beverages while on the drug, and not to drive vehicles if they become drowsy. In all patients kept on the drug for long periods, the drug should be withdrawn gradually to avoid possible serious reactions.

Contraindications: Hyperexcitability, agitated prepsychotic states and a history of previous reactions to meprobamate.

Bamadex® Sequels®

d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.)

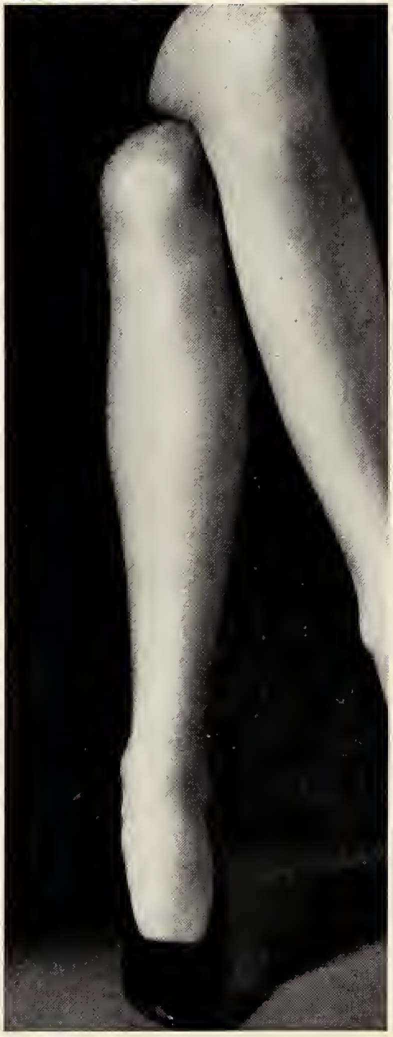
Sustained Release Capsules

LEDERLE LABORATORIES • A Division of American Cyanamid Company, Pearl River, New York Lederle

6655

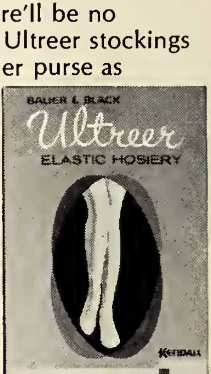
You prescribe elastic stockings.
She won't wear them.
Now what?

Ultreer™



Elastic Stockings so sheer they look like support hose. Both Ultreer and support hose are sheer, shapely, cool and comfortable. But that's where the similarities end. New Ultreer fits firmly and evenly over the entire leg. Gives true therapeutic compression necessary to relieve varicose veins and other leg disorders. They provide the therapy you prescribe. The fashion and economy she demands.

Ultreer stockings have a new low price. So low, she can afford two pairs of Ultreer instead of one pair of regular elastic stockings. There'll be no disagreements there. Ultreer stockings are as comforting to her purse as they are to her legs. New Ultreer are the elastic stockings doctors and women can agree on.



KENDALL
BAUER & BLACK SUPPORTS DIVISION

*Life Expectancy**

Total population		69.9
Males		66.6
Females		73.4
White population	—Males	67.5
	—Females	74.4
Nonwhite population	—Males	60.9
	—Females	66.5
At age 45:	—Males	26.9
	—Females	32.2
At age 65:	—Males	12.7
	—Females	15.9

*These figures are based on 1963 statistics.

NEED $3.5 BILLION TO GIVE AGED POOR ADEQUATE INCOME

The Chamber of Commerce of the United States
a study entitled, "Poverty: The Sick, Disabled and
ed," recommends that minimum benefits paid
der the Old-Age and Survivors Insurance program
hould represent an adequate floor of protection
ainst the loss of job-related income, and reflect
anges in living standards, the cost of living and
e economy."

What would it cost to raise the income of the aged
or to an adequate level?

Answers are provided in a study by Prof. Juanita
. Kreps of Duke University which is appended to
e Chamber report. To provide incomes adequate
r an "economy food-budget plan"—$1,800 for cou-
es and $1,300 for individuals—would cost about
.5 billion a year. Lifting incomes to a more ade-
ate level—$2,500 for couples and $1,800 for indi-
duals would cost somewhat more than 7.5 billion.
is $7.5 billion is a little more than 1 per cent of
current Gross National Product and about 13 per
nt of the cost of national defense.

nly Few Study Economics

"That more than 80 per cent of teen-agers enter-
g high school this year will never take a course
economies, according to a study just completed.
l but about 10 per cent to 15 per cent will emerge
om high school with a very limited understanding
the way the American economic system works."
eprinted from Management Information, pub-
hed by Elliott Service Company, Inc., Mt. Ver-
n, N. Y.)

Need Soon for 77,000 Medical Researchers

To support a projected expenditure level for medical and health-related research of $3 billion by 1970, an estimated 77,000 professional medical research workers will be needed. The expenditures for research approximated $1.3 million in 1965.

Professional workers engaged full or part-time in medical and health-related research rose from 19,200 in 1954 to 39,700 in 1960—a net increase averaging 3,500 per year.

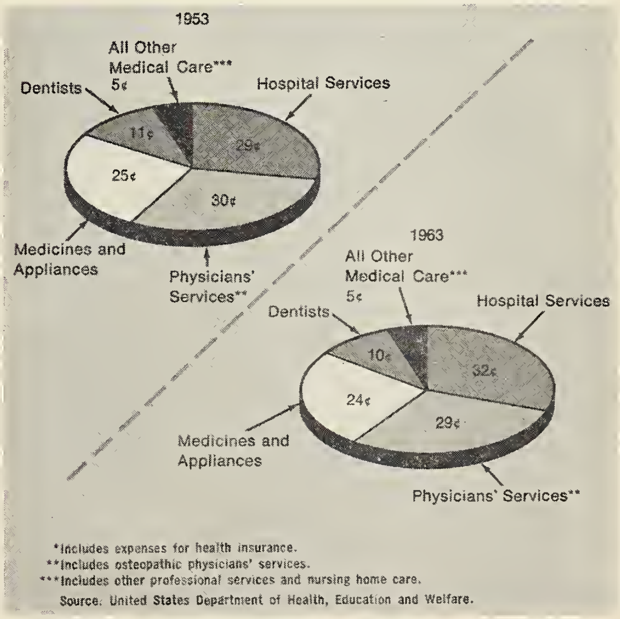
These statistics are reported by the U. S. Department of Health, Education, and Welfare.

Hospital Statistics

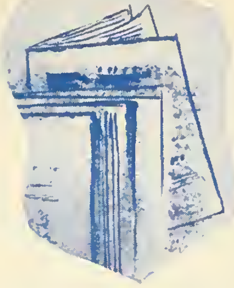
The Michigan hospital industry in 1964 employed 82,466 persons, representing an annual payroll of $361,154,000 which placed it high among the leading industries of the state. Over 75 per cent of all hospital expenses went to payroll, with the remainder being spent for services, equipment and supplies.

The combined plant valuation of Michigan's hospitals stands at $736,058,000, with total assets amounting to more than $869,288,000, and whose total expenses exceed $538,256,000.

Health Care Costs:



*Includes expenses for health insurance.
**Includes osteopathic physicians' services.
***Includes other professional services and nursing home care.
Source: United States Department of Health, Education and Welfare.



Explains Operation Of State Statute Of Limitations

(Editor's Note: The MSMS Council has requested Michigan Medicine *to publish for all members this opinion by MSMS Legal Counsel. The opinion explains the basic operation of the statute of limitations on actions brought against physicians, pointing out that although the period of limitations is two years in malpractice actions and six years in breach of contract actions, it is not wise to place too much reliance on these time periods, particularly in the keeping of records, since many circumstances including minority, incompetency, imprisonment, concealment, etc., may interrupt the running of the statute.)*

Dear Doctor—

I have your recent letter in which you inquire about the maintenance of records, forms and statute of limitations pertaining to x-rays and medical records.

The Michigan statute of limitations on actions for malpractice requires that such action be brought within two years from the time the cause of action accrues. Ordinarily, the cause of action is deemed to have accrued rather than at the time of discovery by the patient. The Supreme Court of Michigan has held, however, that the statute does not begin to run until completion of a course of treatment during which the negligent act was committed.

There are also a number of exceptions to the two-year rule. For example, if a doctor conceals an accident, error or mistake, where it would have been his duty to disclose it to the patient, the statute of limitations does not begin to run until discovery by the patient. Nor does the statute run against minors, insane, or persons imprisoned until the disability ends. Another exception is made if the defendant is out of the state when the cause of action accrues and in such cases the statute does not begin to run until his return.

From the foregoing, it will be noted that it is not safe practice to rely too strongly or literally on the statute of limitations.

I might also call attention to the fact that in cases which allege breach of contract rather than malpractice, the statute of limitations is six years. I mention this because in recent years there has been an increasing tendency on the part of complaining patients to bring actions founded upon alleged breach of agreement to do certain procedures in certain ways rather than to allege merely that the treatment was improperly done.

In my opinion, therefore, (and this is not based on specific statutes or court decisions), a doctor should keep his film and other records for at least seven years and in cases where it is known or suspected that the patient was a minor, insane, or had other disabilities of any kind, records should be kept for a longer period of time.

You asked further with respect to securing patient waivers or consents in connection with the completion of forms submitted to insurance companies and which call for furnishing medical information regarding the patient. Michigan is one of the strictest of states in prohibiting violation of "patient confidence." The Michigan Medical Practice Act (Act 239 P.A. 1899 as amended) not only makes "the willful betraying of a professional secret" grounds for denial or revocation of a doctor's license to practice, but the statute classifies such as "unprofessional and dishonest conduct" which is declared to be a misdemeanor.

Michigan also has a "privilege" statute which prohibits the disclosure of "any information acquired in attending a patient . . . and which was necessary to enable the physician to prescribe for the patient or to do any act for him as a surgeon." It is therefore my opinion that a doctor should obtain the written consent of his patient before disclosing medical information about him.

Sincerely yours,
Lester P. Dodd
MSMS Legal Counsel

So, Act Today

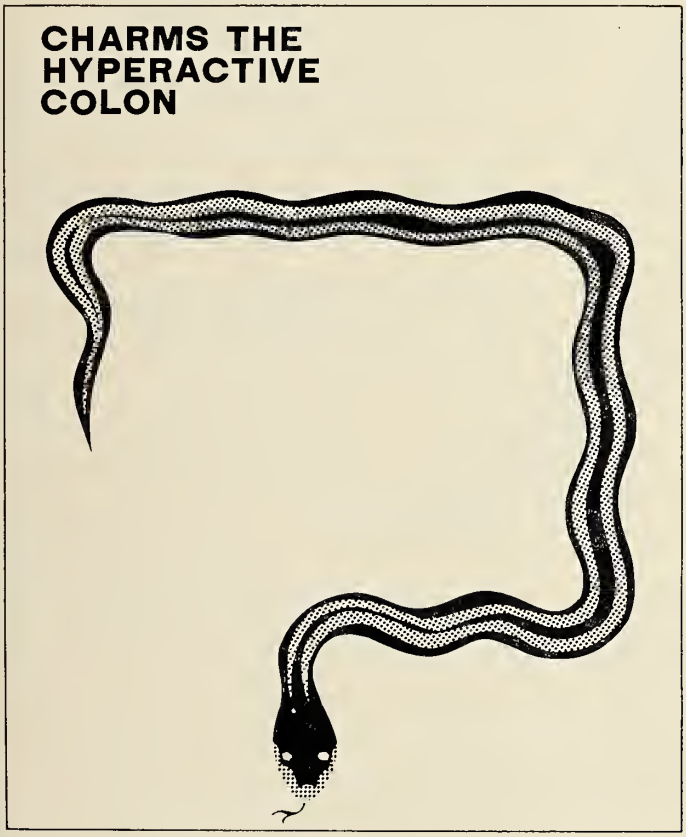
To realize liberty, to tear ourselves loose from political rigging, to unshackle creative energy, to achieve freedom in transactions, does not, as many contend require that the individual wait until all others take these steps in unison with him.

Implicit in such a counsel of delay is the taking of no steps by anyone, this being fatal to liberty.

An individual can stand for liberty all by himself a nation can practice liberty to its own glory and strength, though all other states be slave. The blessings of liberty are conferred on all who live by his credo; and basic to liberty is that the market computer be not rigged. Freedom follows the free market

—Leonard E. Read, *President*
Foundation for Economic Education

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]



CANTIL®

(mepenzolate bromide)

helps restore normal motility and tone

IN BRIEF:

One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide) —25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL —containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

1. Riese, J.A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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EVERY DAY

Regional Health Study Leaders Are Chosen

Leaders for the several regional programs of the Michigan Community Health Services Study have been chosen. The regional task forces are seeking to identify health concerns in such areas as programs, organization, personnel and finances. Study officials report that the groups have accepted the challenge of trying to find the answers.

Orlen J. Johnson, M.D., MSMS past president, of Bay City, is chairman of the Saginaw Valley-Eastern Michigan Task Force.

George Dean, Charlotte businessman, is chairman for the Central Michigan Task Force.

The Michigan Community Health Services Study is sponsored by the Michigan Department of Public Health, Michigan Health Officers Association and the University of Michigan School of Public Health.

Mott Hospital Started

University of Michigan regents have let contracts for the planned 200-bed C. S. Mott Children's Hospital at the University Medical Center. The contracts totaled $7,464,014, with the Miller-Davis Company of Kalamazoo getting the architectural contract.

The seven-story structure will accommodate 50 young patients on each of four upper floors. It will contain its own pediatric x-ray facilities, operating rooms, anesthesia unit and technical services, both will obtain a number of supportive services from the main hospital for the sake of economy.

Heart Diseases Take Big Toll by Far

The National Center for Health Statistics reports that during 1964, diseases of the heart caused the most deaths, accounting for 699,861 out of the national total of 1,798,051.

Next came deaths from malignant neoplasms—cancer—at 369,577. The third leading cause of death was vascular lesions that affected the central nervous system, 198,209.

Accidents came fourth, with 103,843 deaths.

The 1964 mortality statistics were released in January, 1966.

Pathologists Elect

Officers of the Michigan Society of Pathologist have been elected for the New Year. They includ John McDonald, M.D., President, Director of Labo atories, Harper Hospital; Harold E. Bowman, M.D President-Elect, Director of Laboratories, St. Mary Hospital, Grand Rapids, and Edwin M. Knights, Jr M.D., Secretary-Treasurer, Director of Laboratorie Providence Hospital, Southfield.

Describes State Program to Control Rheumatic Fever

By Michigan Department of Public Health

As part of its program of rheumatic fever contro the Michigan Department of Public Health provid to Michigan physicians, through local health depar ments and without charge, Benzathine Penicillin (for monthly injections, to prevent recurrences rheumatic fever in patients who have had one more attacks of this disease. It also reimburses phys cians for injections given patients in low incom families.

In 1965, 40,510 injections of Bicillin were pr vided, in addition to 1,086 bottles of sulfadiazine.

The widespread use of anti-streptococcal proph laxis makes the correct diagnosis of rheumatic fev increasingly important so that erroneously diagnose cases are not subject to prophylactic treatment whic may have some medical and psychological danger The strict application of the Modified Jones' Criteri as printed is considered necessary in the accurat diagnosis of rheumatic fever.

Reporting of acute rheumatic fever in Michiga is required under Section R 325.2, Reportable Di eases, Michigan Regulations for the Control of Con municable Diseases, 1965 (in accordance with th provisions of Act 146, P.A. 1919). The regulatio states that cases and suspects of acute rheumati fever shall be reported to the local health office The list of persons who may report includes: phys cians, dentists, directors of registered labs, parent guardians, superintendents of schools, nurses, an superintendents of public or private hospitals, nursin homes, clinics, dispensaries, asylums or jails.

Evaluation of the cardiac status of recipients state-supplied prophylaxis is provided at the itinerar clinics of the Michigan Department of Public Healt and at medical society clinics on a basis of voluntar physician referral. Continuity of the receipt of pr phylaxis which is the most effective method of pre venting rheumatic fever recurrences, is maintaine for individuals with cardiac damage, through th follow-up programs of local health departments.

Many anxious patients need more than just calming. Stelazine® brand of trifluoperazine offers true tranquilization.

Sedative or muscle relaxant-type tranquilizers are often all that's needed for patients with temporary situational anxiety. But in the many patients whose anxiety presents a continuing problem these agents are limited by their generalized dulling effects.

'Stelazine' can attack anxiety directly without producing annoying dulling effects. On 'Stelazine', patients can react more normally to day-to-day stress yet remain alert, able to carry on their normal activities.

Contraindicated in comatose or greatly depressed states due to CNS depressants and in cases of existing blood dyscrasias, bone marrow depression and pre-existing liver damage. *Principal side effects,* usually dose related, may include mild skin reaction, dry mouth, insomnia, fatigue, drowsiness, dizziness and neuromuscular (extrapyramidal) reactions. Muscular weakness, anorexia, rash, lactation and blurred vision may also be observed. Blood dyscrasias and jaundice have been extremely rare. Use with caution in patients with impaired cardiovascular systems. Before prescribing, see SK&F product Prescribing Information.

SK&F Smith Kline & French Laboratories, Philadelphia

The most significant advance in analgesics since the isolation of morphine in 1805

Remarkable effectiveness and greater freedom from side reactions in the widest range of clinical applications

FOR PAIN

NUMORPHAN®

BRAND OF OXYMORPHONE, ENDO

'A NEW ERA IN PAIN RELIEF'

clinically tested for 5 years/evaluated in 120 U. S. hospitals/over a quarter of a million doses given/ more than 25,000 patients treated

SUPPLIED:
Vials: 10 cc., singly and in boxes of three.
Ampuls: 1 cc. and 2 cc., in boxes of 12 and 100.
(Each cc. of NUMORPHAN* contains 1.5 mg. oxymorphone as the hydrochloride.)
Suppositories: 2 mg. and 5 mg., in boxes of 6.

THE G. A. INGRAM COMPANY
4444 Woodward Avenue, Detroit, Michigan 48201
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*U. S. Pat 2,806,033.

Occupational Disease Reports Mandatory

BY MICHIGAN DEPARTMENT OF PUBLIC HEALTH

The reporting of occupational disease to the sta health department is required by Act No. 210, P., 1937. This law reads in part, as follows:

Sec. 1. On and after the effective date of tl enactment, every physician, hospital superintender or clinic registrar having knowledge of a case of o cupational disease shall within ten days report tl same to the state department of health on a for provided by the state department of health, givi the name and address of the patient, the name ar business address of the employer or employers, tl business of the employer, the place of the patien employment, the length of time of his employme in the place where he became ill, the nature of tl disease, and any other information required by tl state department of health. ALL SUCH REPORT AND ALL RECORDS AND DATA of the sta department of health PERTAINING TO SUC DISEASE ARE HEREBY DECLARED NOT T BE PUBLIC RECORDS. The department of lab and industry shall have access to any such reco in any case where any complaint or suit shall ha been brought before it.

Sec. 1a. An occupational disease, for the purpo of this statute, is an illness of the body which has t following characteristics:

1. It arises out of and in the course of the p tient's occupation.
2. It is caused by a frequently repeated or a co tinuous exposure to a substance or to a specific i dustrial practice which is hazardous and which h continued over an extended period of time.
3. It presents symptoms characteristic of an c cupational disease which is known to have resulted other cases from the same type of specific exposu
4. It is not the result of ordinary wear and te of industrial occupation or the general effect of e ployment or the kind of illness that results from co tacts or activities in life outside the patient's occup tional pursuits.

* * *

Such reporting on the official form (available fr the Michigan Department of Public Health) is i portant to the department's program of occupatio disease prevention. Because there are more th 16,000 industrial plants in Michigan, it is impossi for the department's occupational health engineers eck the details of all industrial operations or even sit every plant in a year's time. Thus the informa- n provided on the occupational disease report form n serve as an indication of hazardous workroom vironment in plants which cannot be visited utinely by the department and accordingly are not spect.

In addition, there are management people who fail provide information concerning disease problems occupational health engineers, and as a result the uses of the health problems go uncorrected.

In theory, then, the occupational disease reporting v helps to alert public health engineers to the pos- ility of disease problems and leads to their cor- tion. In fact, however, the reporting law is of nimal assistance to the division of occupational alth because very few reports are received from ysicians in the state.

* * *

Last year, for example, 80 per cent of the work ort was made on a self-initiated basis, and only 20 r cent was divided up between requests for service d occupational disease reports.

In general, it can be said that all occupational dis- e is preventable disease, whether it is silicosis in foundry, dermatitis in the machine shop, lead isoning in the battery plant, or hearing loss in any isy industry. However, none of these will be pre- nted until and unless the conditions giving rise to em are detected and corrected. To accomplish this, ysicians throughout the state can be of great help promptly reporting all cases they encounter. As natter of fact, it's required by law.

pjohn Supports U-M harmacology Center

The nation's first research and training center de- ted to clinical pharmacology will soon be built at University of Michigan Medical School with a llion-dollar gift from the Upjohn Company.

Its main purposes will be to study drugs' effective- ss and safety in man, to train physicians in the ad- nced skills needed for such study, and to provide a se for patient care related to the research and train- .

The University will seek federal matching funds to pplement the Upjohn gift.

Planning is to begin at once, with construction com- ted by late 1969. Preliminary studies call for a ucture with a large clinical laboratory, examining d monitoring rooms for patients, laboratory and of- space for trainees and staff clinical pharmacolo- ts, and space for support operations such as nurs- , and statistical computation.

The Upjohn Center will be located close to the neral Clinical Research Unit in University Hos- al and the clinical laboratories of the Kresge Med- l Research Building.

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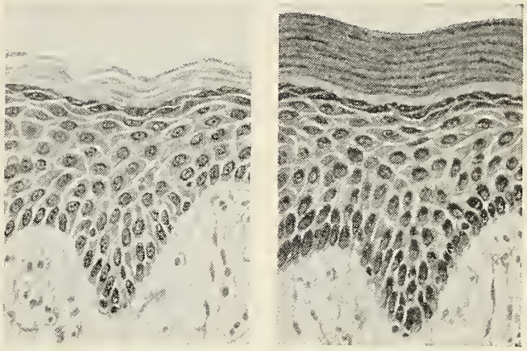
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- Six times the LD_{50} of methoxsalen—only half the dosage of methoxsalen, due to 2X activity.
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CONTRAINDICATIONS: Diseases associated with photosensitivity, such as porphyria, acute lupus erythematosus, or leukoderma of infectious origin.

To date, the safety of this drug in young persons (12 and under), has not been established and is, therefore, contraindicated.

DOSAGE: Adults and children over 12 years: two tablets daily as directed in brochure.

SUPPLIED: Bottles of 28 and 100 coated tablets. *Also available:* Oxsoralen Lotion when the natural botanical is preferred.

References: (1) Becker, Jr., S. W.: J.A.M.A. 173: 1483-1485, 1960; (2) Pathak, M. A., and Fitzpatrick, T. B.: J. Invest. Dermat. 32:509-518, 1959; (3) Pathak, M. A., Feilman, J. H., and Kaufman, K. D.: 33:165-183, 1960.

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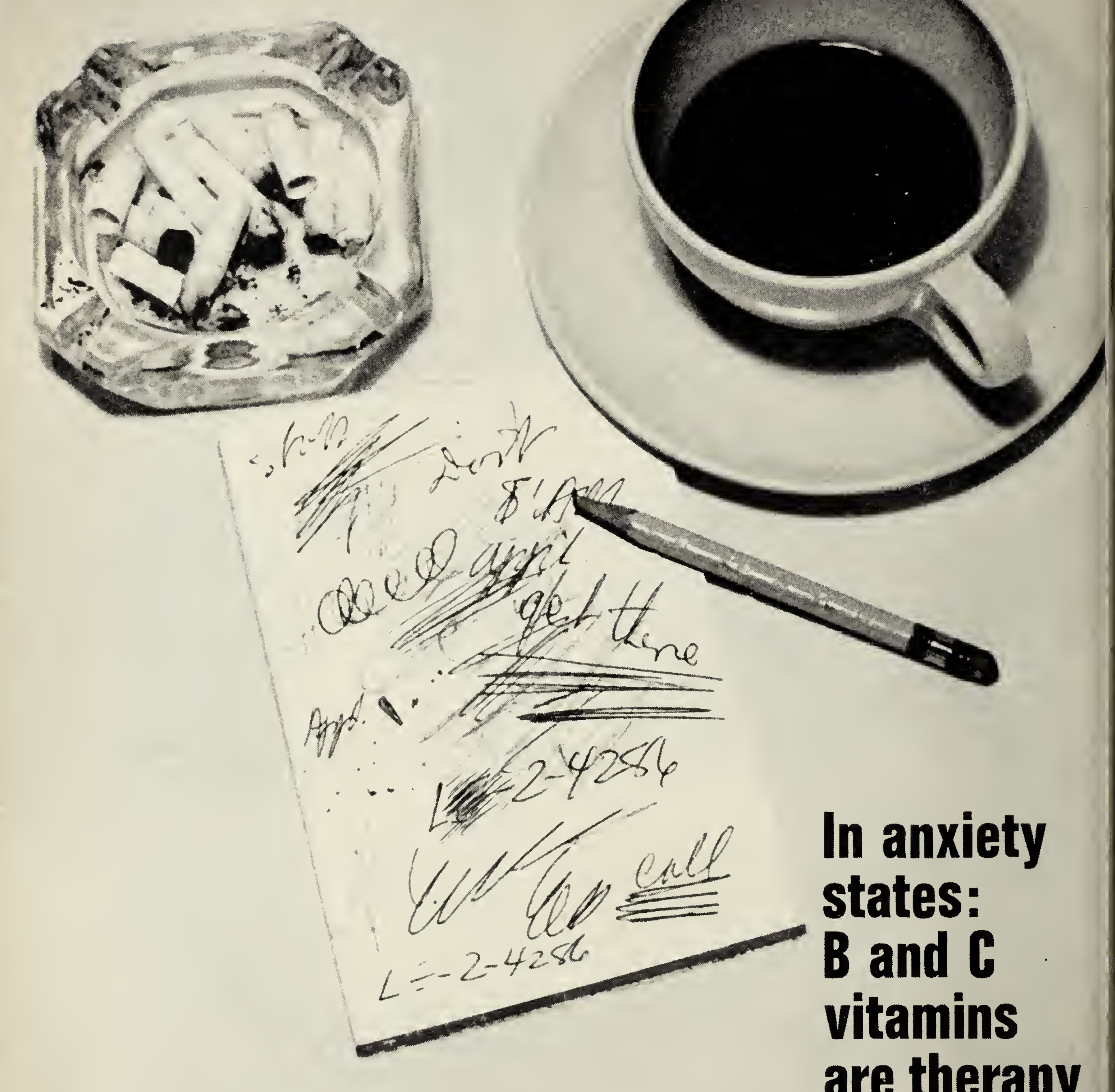

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ENERAL HOSPITAL OLE IN TREATMENT F ALCOHOLISM

**y Ralph Daniel, Chief,
lcoholism Program,
ichigan Department of Public Health**

Many people are concerned about the reluctance physicians and general hospitals to accept alco- lics as legitimately sick people.

The reluctance is understandable. Most physicians ıd most hospitals have had unproductive exper- nces with alcoholic patients. The experiences have en frustrating. They have left the hospital and e physician with the feeling that alcoholics do t belong in the same category as other sick people.

Physicians and hospital personnel who have par- cipated in complete alcoholism treatment do not el this way but this does not counteract the ex- riences and the feelings of those who have had or experiences.

People who are concerned about the reluctance physicians and hospitals to accept alcoholics as gitimately sick people should seek ways to provide r hospitals and physicians productive and satis- ing treatment experiences with alcoholics. A sug- stion about the reason for unproductive experiences ay help.

Alcoholism treatment falls into two areas: The *sults* of excessive use of alcohol and the *cause* of cessive use of alcohol. All successful treatment ograms must recognize both areas of need. Treat- g only the results of excessive drinking is not likely have much permanent result. It is like treating diabetic or a cardiac patient without doing what- er is necessary to get him to learn to live with his ness.

The modern hospital does much more than just ovide beds for patients under a physician's care. ursing services, physio-therapy, laboratories, x-ray, ıd many other paramedical services supplement e physician's work in a variety of physical problems. arge hospitals should have similar services for dealing with the causes of excessive drinking in alcoholic patients. Five hospitals in Michigan now offer these services.

One of the reasons alcoholics have poor reputations with hospitals and physicians is because they have been poor pay risks. This is understandable and preventable. Most alcoholism is unrecognized and untreated in the early stages. Many early-stage alcoholics are treated by physicians and in hospitals where the alcoholism symptoms are missed or disguised. Some hospitals still show a reluctance to admit alcoholics as alcoholics but knowingly admit them under some other diagnosis. A few health insurance companies refuse to pay for alcoholism — this prompts the physicians to hide alcoholism even if it is recognized.

Alcoholism is an expensive illness. It not only causes a drain on the income for the purchase of alcohol, but it frequently causes loss of job and reduction of income. The failure of physicians and hospitals and insurance companies to accept alcoholism as a legitimate illness, and the failure to recognize the early symptoms of alcoholism, forms an "unholy alliance" that permits the deterioration of the patient's ability to pay. Too often one finds that the patient has become medically indigent by the time his alcoholism becomes obvious to all.

Hospitals and physicians who recognize and accept the early symptoms of alcoholism as warnings of a progressive illness find that alcoholics are good patients who respond to treatment and who pay their bills. The alcoholic patients who have built a bad reputation for all alcoholic patients, are the ones whose illness has gone unrecognized and untreated.

General hospitals should admit alcoholics *as alcoholics* and accept alcoholism as a legitimate illness.* Hospital personnel should be expected to be free from the outmoded beliefs that alcoholism is a word to be whispered or cloaked with a stigma. Larger hospitals should establish alcoholism treatment programs to supplement the physician's treatment of the *results* of excessive drinking. Smaller hospitals should expect their staffs to recognize that treatment of the results of excessive drinking is not complete treatment of alcoholism and they should be able to refer patients to local resources such as Alcoholics Anonymous and alcoholism centers.

The Michigan Department of Public Health, through its Alcoholism Program, is prepared to provide assistance to any hospital that is concerned about improving its services to alcoholic patients. The 1966-67 budget request provides for subsidizing two existing hospital programs and three or four new programs that are currently in the planning stages at other hospitals.

And More, Too!

"A medical journal should be a motion picture, a love letter, a love song and a continuous message in keeping its readers up to date."

So stated Carey P. McCord, M.D., editor of the "Journal of Occupational Medicine," at the American Industrial Health Conference in New York recently.

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*This has been officially recommended by the American Hospital Association and the American Medical Association.

PUBLIC
RELATIONS

Good MD Image Up to Doctor

By Brock E. Brush, M.D., Chairman
MSMS Public Relations Committee

As the Public Relations Chairman of the MSMS, I would strongly urge each MSMS member during 1966 to try to make the public more aware of the good works of our profession.

The public in general, I believe, is very pleased to read about the great medical discoveries and to hope that many of today's revelations will be applicable for their particular condition in the near future.

Most citizens are very fond of their family physician and are pleased with the service he is rendering. When it comes to a judgment of the profession as a whole, however, many people have been somewhat disenchanted with the services and the costs. Unless one studies an accurate breakdown of the problem, it is hard for the average person to understand how hospitalization could be so expensive. While the costs of maintenance and repairs to televisions, automobiles, and home are ever on the increase, the public cannot believe the medical costs should also increase. The days of the three to five dollar office visit remains vividly in their mind.

Together we need to acquaint the public with the great increase in the use of the expensive technical equipment needed to perform the ever-increasing number of tests which are obtained today. The increased magnitude of surgical procedures, such as heart operations with the need for several transfusions and more postoperative care has greatly increased medical costs. If all the facts are presented to the patient the image of the physician would be even higher.

Each of us must resolve to do some public relations work for our profession. We must remind each other that although we may be extremely busy, our individual care, attention, and cordiality to patients is what determines their attitude toward our profession.

In the transitional days which lie ahead of us, every physician must maintain his composure, patience and kindly attitude towards all who seek his services.

ONE GOAL ALWAYS

To the prophets of "doom and gloom," I woul assert that the future of the physician is a glorious one He is now, and will continue to be, the key man i the health care of the nation. His profession has trul become a great intellectual one, encompassing all th social, physical, and biological disciplines of our grea universities.

The flood of scientific knowledge has put into hi hands, weapons of undreamed-of power of attack, t halt, and frequently to eradicate disease. The physician is the pivotal figure in the prompt and perceptive utilization and application of biomedical information for the benefit of mankind. Only the physician who knows how to care for patients can fill thi role.

Our medical schools will never concentrate exclusively on research, even though some individuals thin this is coming to be true.

It is comforting and challenging to realize that al the activities of our medical schools—education, research, the application of research findings to man superb patient-care, and concern for the health of th nation—are directed toward one goal: the welfare o mankind.

Does the medical profession find any fault in this?
Are there any real divisions between us?
I think not!

—Samuel Gurin, Ph.D.
Dean, School of Medicine
University of Pennsylvania

Wm Beaumont
HIS ASSOCIATION WITH
MEDICAL EDUCATION

Thanks to an exhibit by three MSMS members, the delegates at the AMA Clinical Convention in Philadelphia learned more about the contributions of Michigan's William Beaumont, M.D. A gastroenterology exhibit was developed by Alfred H. Wittaker, M.D., Alexander Walt, M.D., and William Loechel, M.D., for Wayne State University, to present a pictorial history of Doctor Beaumont's associations with medical education. Included were his apprenticeship in Vermont, his work on Alexis St. Martin, and his later period in St. Louis.

Night Leg Cramps...
Frequent Bedfellow in Diabetes, Arthritis, and Peripheral Vascular Disorders*

*"Nocturnal cramps occurring in the calf muscles and small muscles of the feet have been encountered in a significant number of diabetic patients."[1]

"... nocturnal cramps may be the presenting symptoms of patients with arteriosclerosis obliterans, deep thrombophlebitis, varicose veins, osteoarthritis..."[2]

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Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose... helps restore restful sleep.

QUINAMM Prescribing Information: Composition: quinine sulfate 250 mg. and aminophylline 200 mg. per tablet. **Precautions:** aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue if ringing in the ears, deafness, skin rash or visual disturbances occur. Since Quinamm contains quinine sulfate, caution should be observed regarding administration during pregnancy. Dosage: 1 tablet three or four times daily. For nocturnal leg cramps, 1 tablet on retiring.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angiology, 12:102, 1961. 3. Rowls, W., et al.: Med. Times, 87:818, 1959.

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ANCILLARY
MEETINGS

Medical Writers to Meet

The Michigan Chapter of the American Medical Writers' Association invites interested physicians to participate in their evening dinner and program at the Pontchartrain Hotel in Detroit, April 27.

Following the dinner and election of officers, the Chapter will offer a panel on editing, a panel on communications and a general discussion. Recognized Michigan authorities on medical writing and communications will participate.

C. Howard Ross, M.D., Ann Arbor, is the Michigan president.

TB Action Needed

Tuberculosis is still a major health problem in the U.S., said Sidney H. Dressler, M.D., U. S. Public Health Service, speaking before the 1965 annual meeting of the Michigan Tuberculosis and Respiratory Disease Association at Kellogg Center, MSU. Dressler said that the tuberculosis problem couldn't await the development of a miracle drug to bring it under control. He said an additional $25,000,000 will have to be spent annually in TB control, raising the annual cost from $40,000,000 to $65,000,000 if they are to have any adequate control of the disease. These figures represent the need for increased case detection, treatment and follow-up of patients, suspects and contacts, and do not include support for continued clinical research toward the development of an anti-TB vaccine.

"ALCOHOLISM is a DISEASE"

The Keeley Institute, Dwight, Illinois, specializes in the individual and group care of those having a drinking problem.

Our progressive, well-rounded program is conducted in an atmosphere of friendly cooperation under the direction of physicians and experienced personnel. We take female patients as well as male.

The alcoholic can be helped . . .

Why not write now for detailed information on our low cost, comprehensive services — or phone 815 584-3001.

The Keeley Institute is a member of the American Hospital Association — Licensed by the Dept. of Public Health, State of Illinois.

John R. G. Gosling, M.D., University of Michigan associate professor of Ob/Gyn, was one of the speakers at the Regional Family Planning Conference at Oakland University. MSMS and other medical organizations cooperated in a series of regional sessions to explain new state legislation dealing with family planning. (Photo by the Michigan Department of Public Health)

From the Mailbox

(Note: Letters were sent to all the Michigan Medicine advertisers thanking them for their support in 1965. Following is a typical reply:)

Dear Doctor Leader:

Thank you for your letter commenting on our advertising support for MICHIGAN MEDICINE.

We have long appreciated the interest in and support of our preparations by you and our colleagues in Michigan. It is our expectation to continue the advertising program as heretofore.

Cordially yours,
B. S. FUCHS, *President*
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New York City

As Vice President of Friends, Dade County Suicide Prevention Volunteers, we are naturally interested in all pertinent information regarding the problem.

We would be glad to reimburse you for a copy of the MICHIGAN STATE MEDICAL SOCIETY JOURNAL, Vol. 2, No. 1 (January 1963) that contains the article, "Emergency Response to Potential Suicide," by Robert E. Litman, M.D.

Thanking you in advance,
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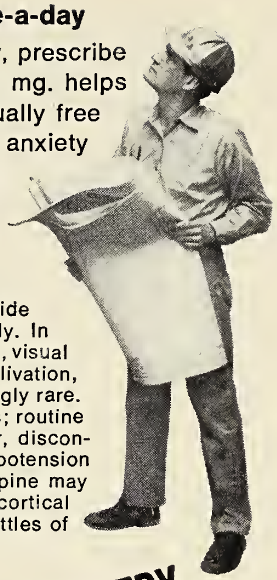
Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.



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In Memoriam

Andre J. Cortopassi, M.D., Saginaw

Andre J. Cortopassi, M.D., 62, died January 12 at Saginaw General Hospital where he was a member of the medical staff.

Born in Boston Location, Houghton County, Doctor Cortopassi received his degree in medicine from the University of Michigan in 1926. After a year's internship at Saginaw General Hospital, he began a period of further training in ear, nose and throat treatment and surgery at the University of Pennsylvania, and abroad at the University of Vienna. Since 1939 he had been associated in an ear, nose and throat specialty partnership in Saginaw with his brother, Doctor V. E. Cortopassi.

Doctor Cortopassi was a past president of the Saginaw County Medical Society, and active in civic affairs of Saginaw. His medical memberships included the American Board of Otolaryngology, American Academy of Otolaryngology, the American Society of Facial Plastic Surgery, Saginaw Valley Academy of Otolaryngology and Ophthalmology, Detroit Otolaryngological Society, Pan-Pacific Surgical Society and the Centurion Club for Deafness Research. Dc tor Cortopassi was also a Fellow of the Americ College of Surgeons and the International College Surgeons.

His brother, V. E. Cortopassi, M.D., of Sagina is among the survivors.

Aaron Dubnove, M.D., Detroit

Aaron Dubnove, M.D., Detroit physician, di January 6 at age 74.

Born in Russia, Doctor Dubnove came to Cana in 1913 and received his medical degree at the U versity of Manitoba, where he later established loan fund for needy students. In the past few ye Doctor Dubnove also established loan funds at t medical school of the Hebrew University in Jer salem and Bar-Ilan University. Doctor Dubno came to Detroit in 1921, interned at St. Mar Hospital and practiced medicine in Detroit since th time.

Doctor Dubnove was a life member of the Michig State Medical Society.

Albert R. Parker, M.D., Wayne

Albert R. Parker, M.D., general practitioner Wayne for 40 years, died January 30 at the age 66.

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In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

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A native of Grand Blanc, Doctor Parker was a 25 graduate of the University of Michigan School Medicine. Doctor Parker was a former chief of aff of the People's Community Hospital Authority d Selective Service Medical Advisor. He was afiated with Annapolis Hospital, Wayne.

Doctor Parker's great great-grandfather, Cyrus ldwin, M.D., was the first white doctor to practice edicine in Genesee County, and his father, James illis Parker, M.D., practiced 40 years in that unty.

Among the survivors are two sons, Alden Parker, .D., and John Parker, M.D.

Joseph Wruble, M.D., Detroit

Joseph Wruble, M.D., 64, Detroit general practiner, died February 3, at Woman's Hospital, where was a staff member.

A graduate of the University of Michigan School Medicine in 1926, Doctor Wruble was a Detroit sident for nearly 50 years. He was born in Newport ews, Virginia.

Doctor Wruble was also on the staff of Sinai Hostal and was a member of the Maimonides Medical ciety.

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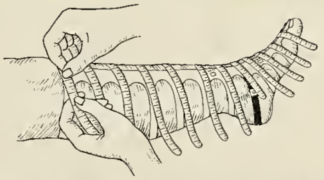

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Welcome, New Members

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John N. Browell, Jr., M.D., Henry Ford Hospital, Detroit, Michigan

Constantine T. Cerkez, M.D., Pontiac Medical Building, 35 S. Johnson, Pontiac, Michigan 48053 *(Internal Medicine)*

Ross J. Collie, M.D., 1209 Willow St., Port Huron, Michigan

Raymond M. DeHaan, M.D., Upjohn Company, Kalamazoo, Michigan

William B. DeLong, M.D., 119 Virginia Avenue, Ann Arbor, Michigan *(Neurological Surgery)*

David K. Hickok, M.D., 3425 Richard, Ann Arbor, Michigan *(Pediatrics)*

Paul S. Johnson, M.D., 3007 Geddes Avenue, Ann Arbor, Michigan

Frank O. Kadrnka, M.D., Upjohn Company, Kalamazoo, Michigan

Glen H. Kumasaka, M.D., 1411 Harbrooke, Ann Arbor, Michigan *(Roentgenology, Radiology)*

Donald Lipsey, M.D., Durand, Michigan

John C. Mall, M.D., 1429 Sheridan, Plymouth, Michigan *(Internal Medicine)*

Jack F. Martin, M.D., 1011 N. Michigan Avenue, Saginaw, Michigan *(Surgery)*

William O. Mays, M.D., 3220 W. Boston Blvd., Detroit, Michigan 48206

John A. Maxwell, M.D., 2395 Yost Blvd., Ann Arbor, Michigan

John C. Parker, M.D., 610 N. West Avenue, Jackson, Michigan *(Obstetrics-Gynecology)*

Roger Paterson, M.D., Box 367, Northport, Michigan *(General Practice)*

G. Jay Rottman, M.D., 200 S. Franklin St., Greenville, Michigan

Forrest Scharf, M.D., Midland Hospital, 4005 Orchard Dr., Midland, Michigan *(Pathology)*

Sheldon A. Schwartz, M.D., 1121 Maiden Lane Ct., Ann Arbor, Michigan

Donald S. Smith, Jr., M.D., 2715 Ashman, Midland, Michigan *(Internal Medicine)*

Donald E. Stroude, D.D.S., 8425 Twelve Mile Rd., Warren, Michigan

Rustico C. Tongco, M.D., 3260 McDowell, Ferndale, Michigan, 48220 *(Surgery)*

Hugo Uhland, M.D., Dow Chemical Company, PO Box 469, Midland, Michigan, 48641 *(Internal Medicine)*

Robert L. VanSickle, M.D., 616 Sheffield Rd., Pontiac, Michigan *(Pediatrics)*

Dieter Voss, M.D., Henry Ford Hospital, Detroit, Michigan

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Indications: 'Deprol' is useful in the management of depression, both acute (reactive) and chronic. It is particularly useful in the less severe depressions and where the depression is accompanied by anxiety, insomnia, agitation, or rumination. It is also useful for management of depression and associated anxiety accompanying or related to organic illnesses.

Contraindications: Benactyzine hydrochloride is contraindicated in glaucoma. Previous allergic or idiosyncratic reactions to meprobamate contraindicate subsequent use.

Precautions: *Meprobamate*—Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Side effects associated with recommended doses of 'Deprol' have been infrequent and usually easily controlled. These have included drowsiness and occasional dizziness, headache, infrequent skin rash, dryness of mouth, gastrointestinal symptoms, paresthesias, rare instances of syncope, and one case each of severe nervousness, loss of power of concentration, and withdrawal reaction (status epilepticus) after sudden discontinuation of excessive dosage.

Benactyzine hydrochloride—Benactyzine hydrochloride, particularly in high dosage, may produce dizziness, thought-blocking, a sense of depersonalization, aggravation of anxiety or disturbance of sleep patterns, and a subjective feeling of muscle relaxation, as well as anticholinergic effects such as blurred vision, dryness of mouth, or failure of visual accommodation. Other reported side effects have included gastric distress, allergic response, ataxia, and euphoria.

Meprobamate—Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Dosage: Usual starting dose, one tablet three or four times daily. May be increased gradually to six tablets daily and gradually reduced to maintenance levels upon establishment of relief. Doses above six tablets daily are not recommended even though higher doses have been used by some clinicians to control depression and in chronic psychotic patients.

Supplied: Light-pink, scored tablets, each containing meprobamate 400 mg. and benactyzine hydrochloride 1 mg.
Before prescribing, consult package circular.

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even when complicated by anxiety, tension, insomnia, agitation or rumination.

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PERSONAL MENTION

Henry K. Schoch, M.D., Ann Arbor,
will direct a cancer research program, financed by a recent grant of $26,625 to the University of Michigan from HEW.

Herbert Raskin, M.D., Detroit,
will speak at the Illinois State Medical Society's Conference on Narcotic Addition in Chicago, March 24-25. Doctor Raskin is a member of the AMA Council on Mental Health's Committee on Addiction.

Arthur J. Vorwald, M.D., Detroit,
has been appointed as a member of the six-man State Air Pollution Commission, by Governor Romney.

Stuart M. Gould, M.D., Ann Arbor,
staff psychiatrist of Mercywood Hospital, attended the annual convention of the National Association of Private Psychiatric Hospitals in New Orleans. He also continued on to the Fifth Overseas International Medical Conference held in Yucatan, Mexico.

Samuel P. Hicks, M.D., Ann Arbor,
spent two weeks recently in Russia as a guest of the Soviet State Committee for the Utilization of Atomic Energy. He reports they were exploring the use of Radioisotopes in Diagnosis, the neurophysiology of vision, irradiation of tissue cultures, the effects of various agents on conditioned reflexes, and the efforts of radiation on the protein structure.

F. J. Fitzsimmons, M.D.,
is the new medical director of the Fisher Body plant at Kalamazoo. He formerly was in private practice in Tawas City and Adrian, and worked for Fisher in Flint and Tecumseh.

M. A. Hoffs, M.D., Lake Odessa,
is the new medical director of the Barry County Medical Care Facility. He succeeds Herbert Wedel, M.D., who died in November.

H. S. Heersma, M.D., Kalamazoo,
is new President of the Kalamazoo Association of Retarded Children.

Survey Tells More About Med Students

A recent study by two University of Michigan professors showed that only 13 per cent of freshmen medical students in the past five years were "A" students—to further blast the misconception that only top scholars are admitted.

The vast majority (73 per cent) of freshmen medical students were "B" students and 14 per cent were "C" students.

Among the other findings was the unusual frequency of eldest sons as medical students. Two-and-one-half times as many eldest sons of families as youngest sons entered medical school, the report found. The researchers concluded that fathers who fail to achieve some of their own ambitions may strongly influence the aspirations of their sons—and especially the eldest sons.

The study was conducted by Professors Sidney Cobb and J. R. P. French, Jr., of the U-M Institute for Social Research.

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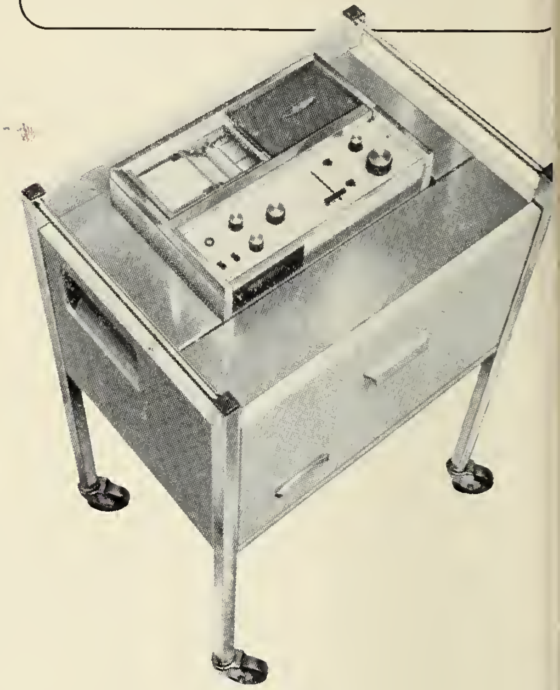

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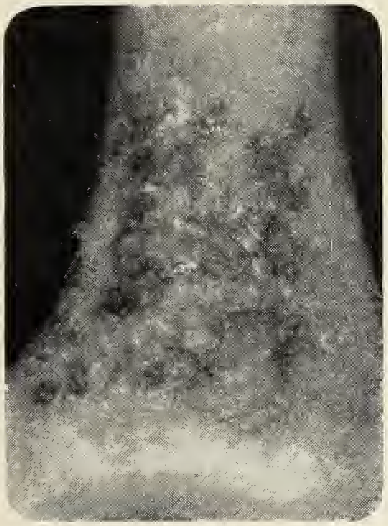
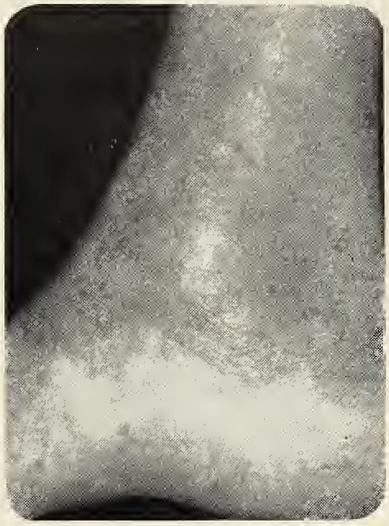
eczema: scourge of childhood



R. R., Age 11—Before treatment— atopic eczema of long standing



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raindications: Tuberculosis of the skin, herpes simplex, en pox and vaccinia.

utions and Side Effects: Do not use in the eyes or in ar (if drum is perforated). A few individuals react unably under certain conditions. If side effects are entered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

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ACAPULCO-MEXICO CITY SEMINAR

The Michigan Chapter of American Trial Lawyers is holding a Seminar in Acapulco and Mexico City from April 12, 1966, to April 24, 1966. This is a 13 day package deal and the price is $336.00 per person (wives, children and relatives welcome).

The package includes air transportation by Jet from Detroit Willow Run Airport and return, plus hotel room, baggage handling and seminar. On the return trip we will stop over for a long weekend in Mexico City, and this is included in the price. We are not including meals because there are many fine restaurants in Acapulco and Mexico City that you will want to visit. This rate is based on two persons to a twin room. It does not include tips, drinks, room service, valet, or porter service.

The Seminar is offered to the members of the Michigan State Medical Society and the State Bar of Michigan and it will deal with legal problems of the doctors and medical problems of the lawyers, and will consist of morning lectures (9:30 to 11:30) and afternoon round table discussions.

We leave Willow Run Airport on the morning of Tuesday, April 12, 1966, and arrive in Acapulco in the early afternoon. We will leave Acapulco for Mexico City on Friday, April 22, and will spend Friday and Saturday in Mexico City, leaving Sunday for return to Willow Run.

This package is offered to only 132 persons on a first come first served basis.

If you wish to go, fill out the stub below and send it to me with your check. In the event you later find it necessary to cancel out for any reason, we will not be able to refund the full price because we have certain expenses plus a hotel deposit which must be covered. We will refund $250.00 of the $336.00 package price.

Remember, it's first come first served and only 132 persons can go.

Sincerely yours,

LEE C. DRAMIS,
Seminar Chairman

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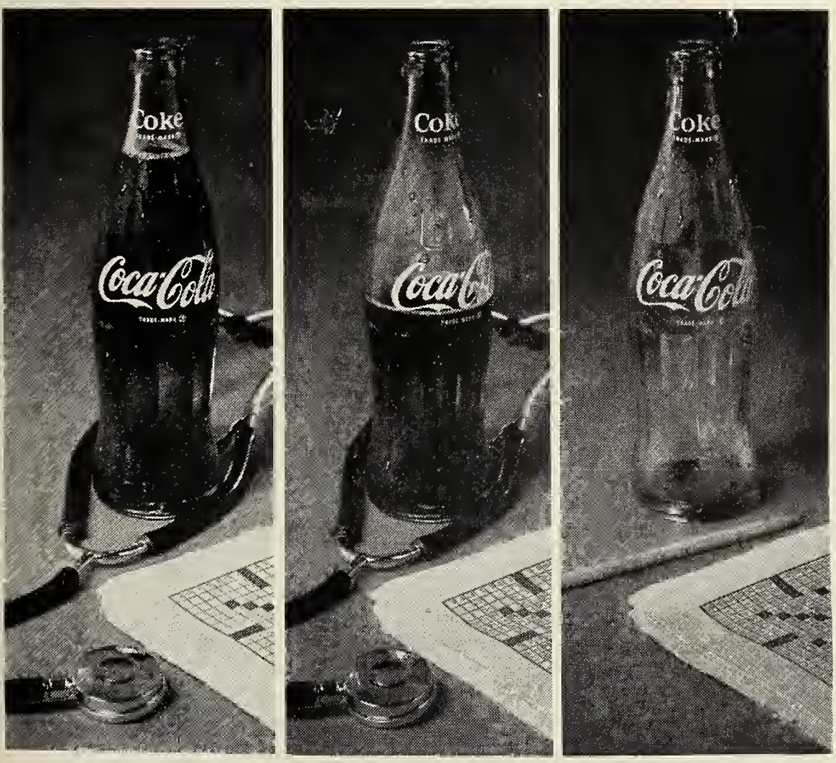

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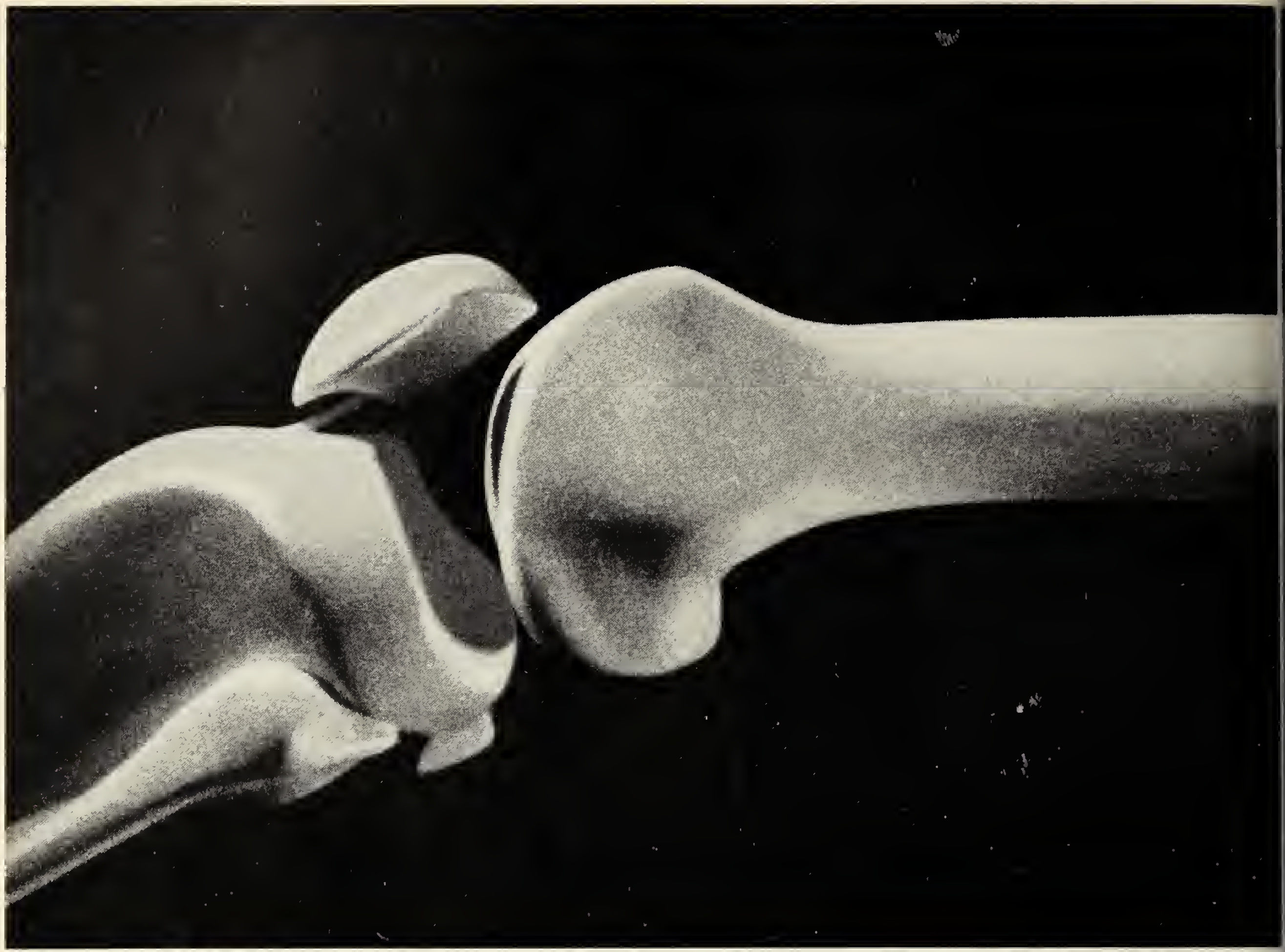

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Precautions
Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patient should be closely supervised and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Make regular blood counts. Use greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy.

Adverse Reactions
The most common are nausea, edema and drug rash. Hemodilution may cause moderate fall in red cell count. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported but cannot definitely be attributed to the drug. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hepatitis, jaundice, and several cases of anuria a hematuria. With long-term use, reversib thyroid hyperplasia may occur infreque

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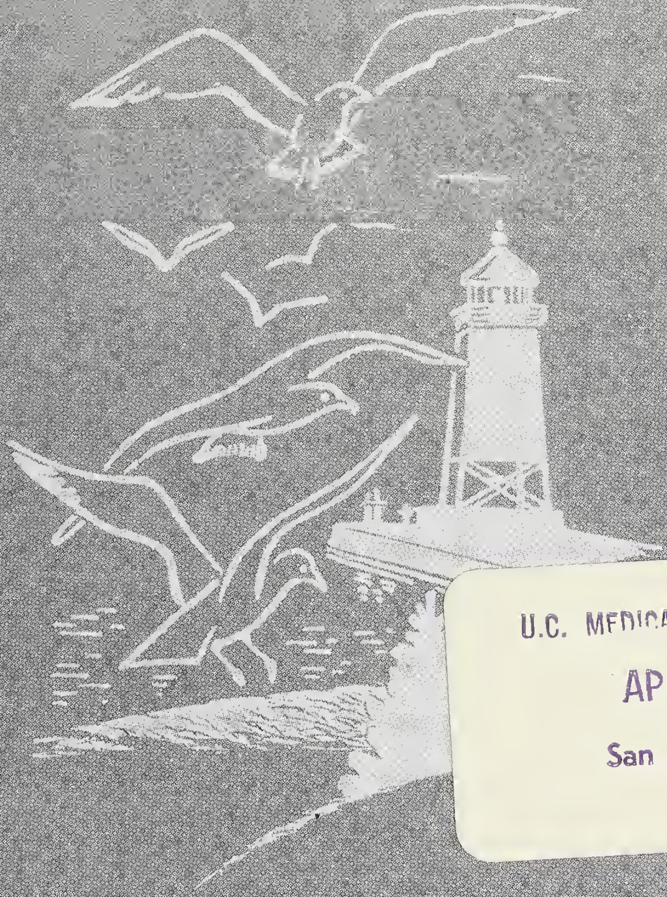

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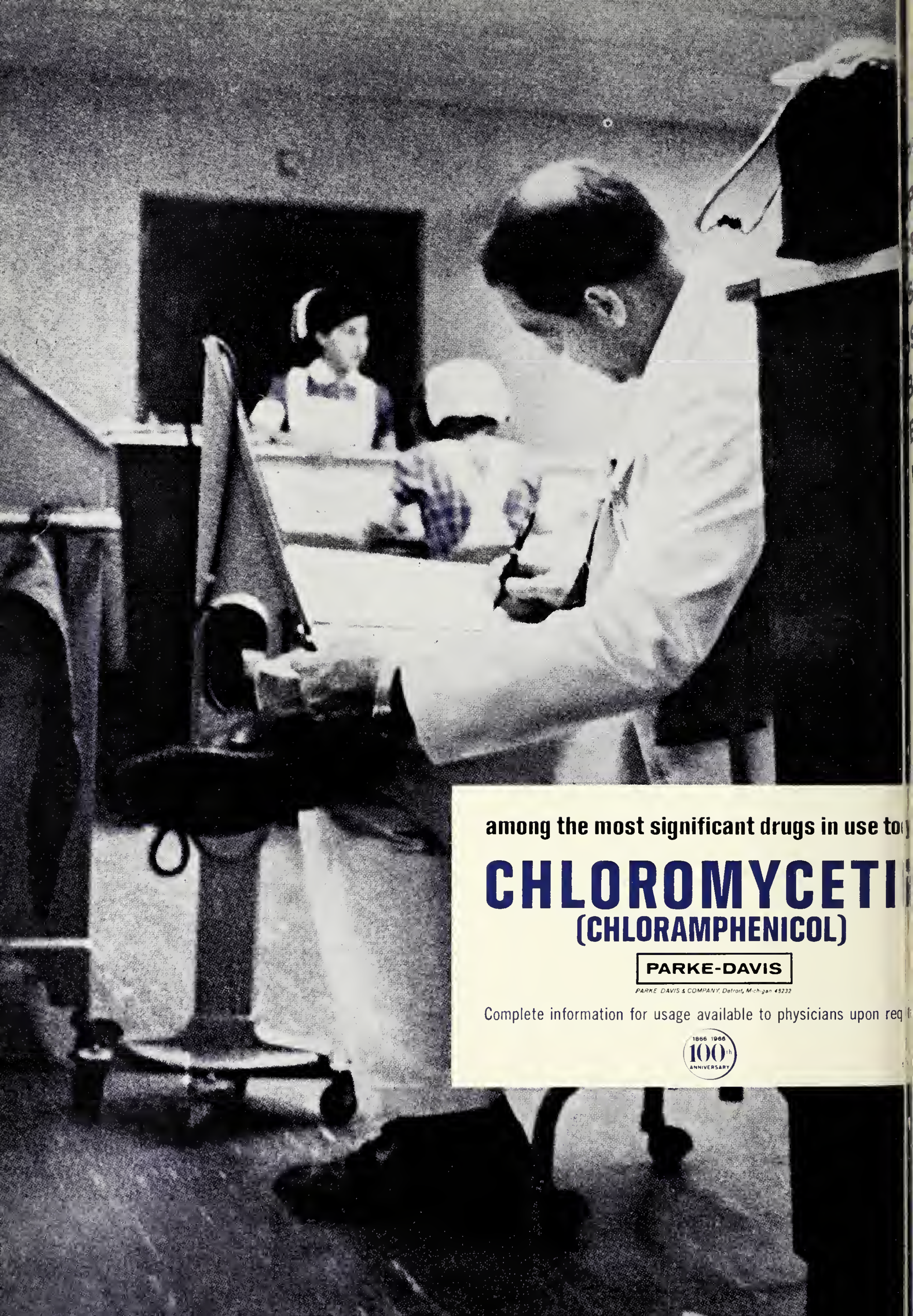

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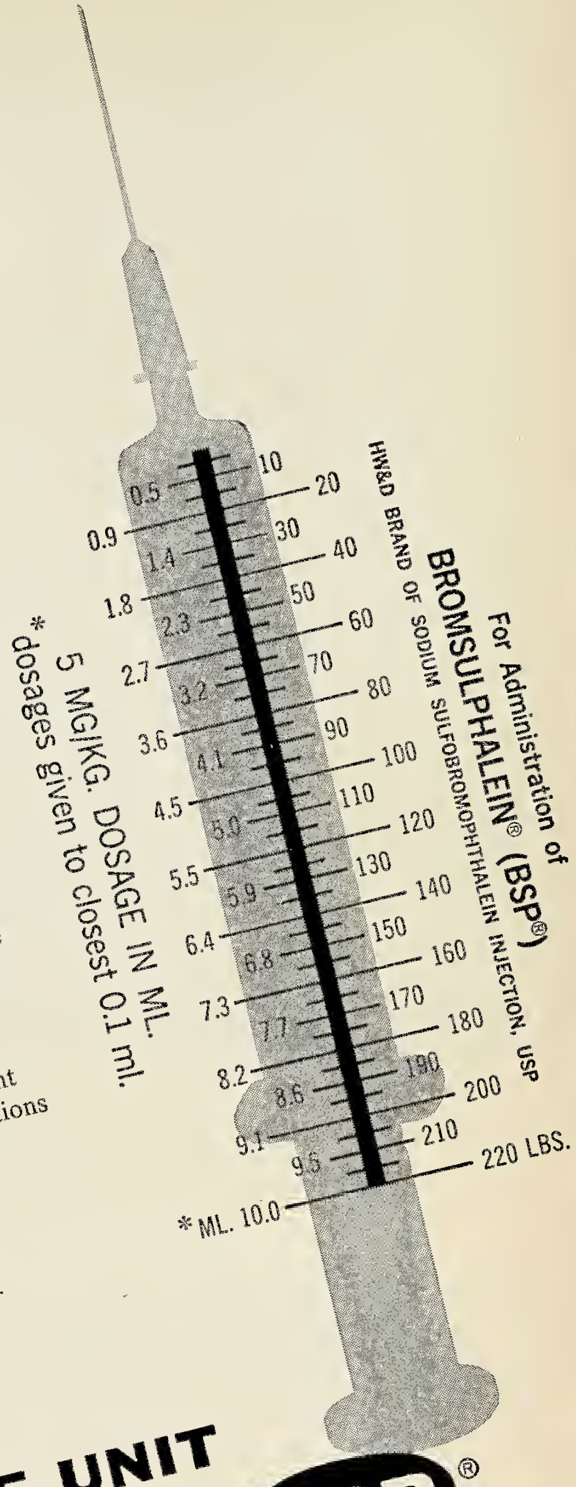
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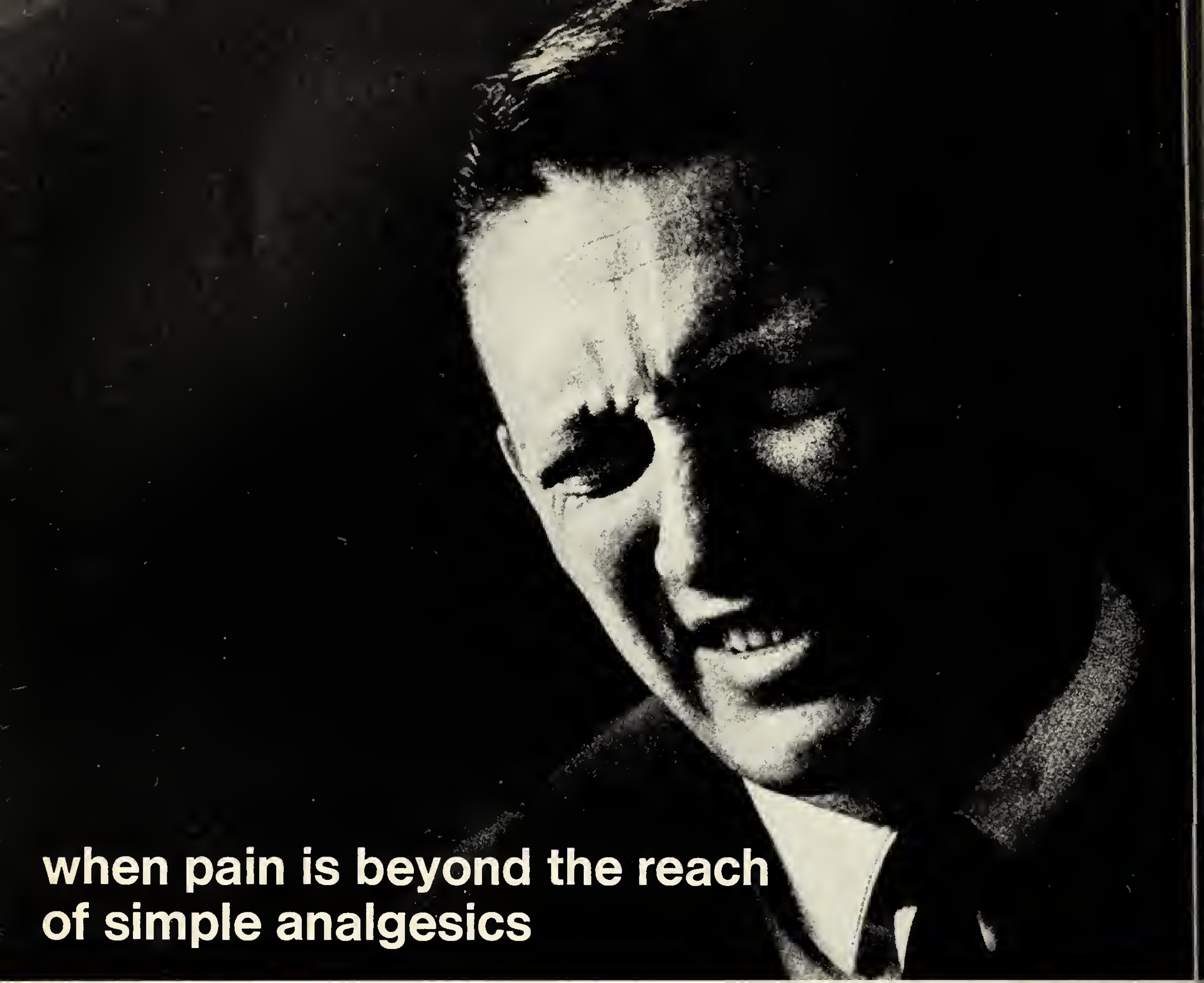

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1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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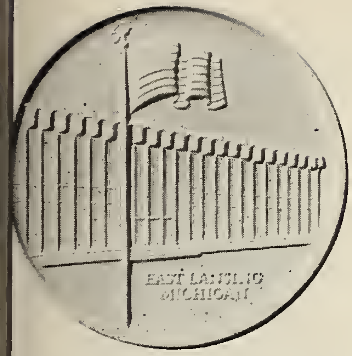

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usiness Manager
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he cover layout about the MSMS
pring Postgraduate Calendar util-
zes a typical Lake Michigan light-
ouse and sea gulls. The sketch is
mely as physicians look forward
o the spring PG activities, the
ourist season, vacations, etc. The
rt work was done by Rev. Harold
. Kohn, a writer and artist at
harlevoix.

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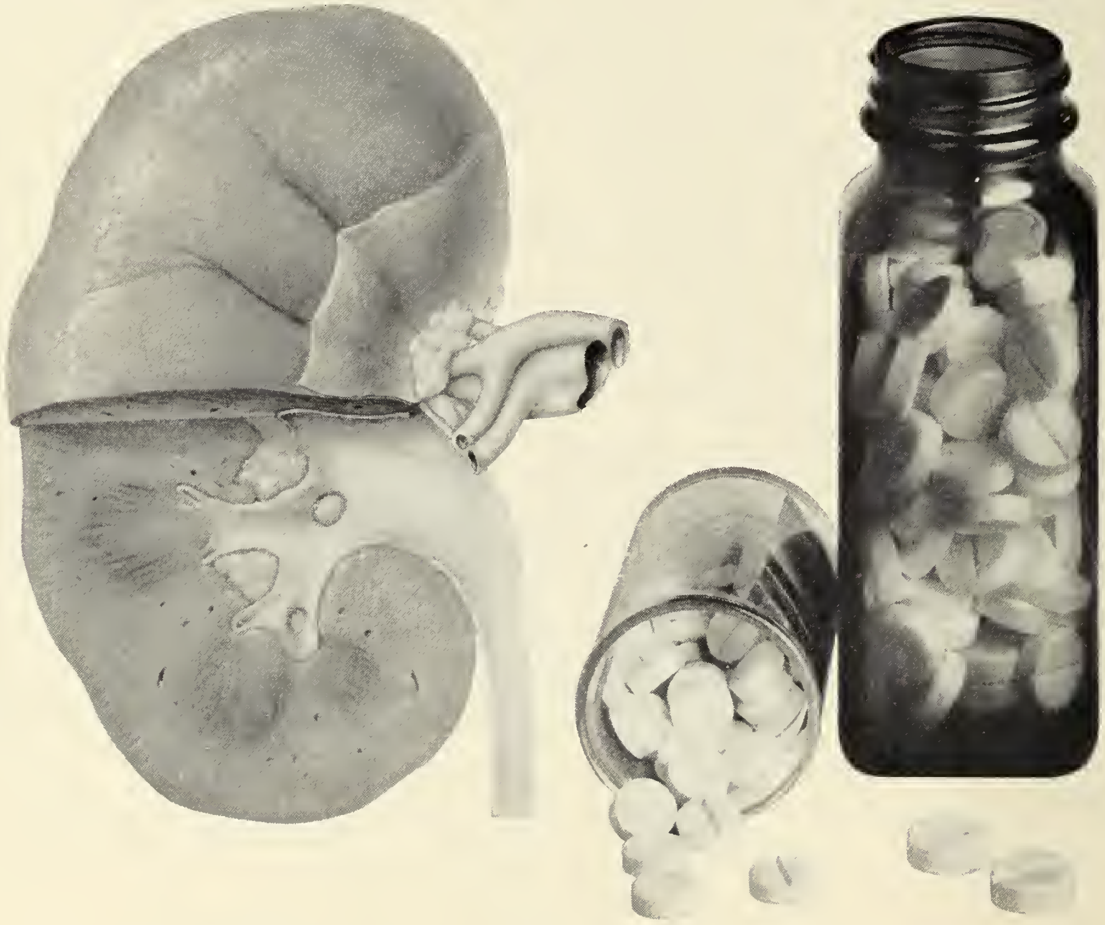
Published monthly, except two extra issues to be published in October and December, by the Michigan State Medical Society
s its official journal at 2642 University Ave., Saint Paul, Minn. 55114. Second class postage paid at Saint Paul, Minnesota.
early subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union,
2.50 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, ex-
hanges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East
ansing, Michigan 48824. © 1966 Michigan State Medical Society.

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

- Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.
- From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

THE FORUM QUESTION THIS MONTH:

Do you believe that hospital planning by law could become a brake or an incentive for innovation toward better quality and economy of medical care?

R. C. Deming, M.D.

O. J. Johnson, M.D.

ichard C. Deming, M.D.

ackson

Better quality and economy in hospital planning is ot obtained by law (government). On the contrary -voluntary local planning does promote more effi- ient use of area hospitals and effective savings in ublic funds.

There is little evidence that hospital planning by overnment (law) provides either improvement in conomy or quality of hospital services. The Vet- rans Administration Hospitals and the People's ommunity Hospital Authority are good examples f high cost and low efficiency.

Voluntary area wide planning with the highly im- ortant factor of participation by local interested itizens will reduce costs by preventing reduplica- ion of facilities, service and equipment, locally and ersonally checked. The quality will be as good as its itizens demand.

The government should not do for the people what hey can well do for themselves.

oel I. Hamburger, M.D.

outhfield

First, wherein are hospitals uneconomical and nadequate?

The greatest deterent to economy is cost-plus re- nbursement by Blue Cross. This encourages such hings as unnecessary duplication of expensive labora- ry functions for their "prestige" value. Complex tudies done infrequently increase costs, often provide rroneous data and discourage development of high uality, efficient, regional specialty laboratories.

Is room service necessary? Most patients would enefit from the activity of obtaining meals at a entral cafeteria, and some from doing their own ousekeeping.

Nursing is the weakest element qualitywise. To ompensate for the nursing shortage the "team sys- em" was conceived. The nurse is replaced by two r three persons, often of the high school dropout aliber. (No wonder the recent—and not so recent— dverse publicity on nursing errors.) The "team sys- em" increases the number of hospital personnel while imultaneously decreasing the quality of care.

Solving these and other serious problems which ave shaken public and professional confidence in hospital care requires reorganization of thinking to provide real incentives for economy and quality. Does anyone really think legislation would do this?

Orlen J. Johnson, M.D.

Bay City

There probably should be a planning program for hospital construction. To date it is pretty well accepted that the existing program has provided the public with good quality hospital facilities in general. Where voluntary restrictions have been applied, there have been outcries of injustice. But in the main the public has been able to act to meet its needs.

Legislation to govern hospital construction which has been proposed so far smacks of bureaucratic control. It goes beyond franchising for construction, with regulations for the hospital operation and medical functions. These latter, though objectionable, are with us in the recent health program enacted by the government.

The effect of official planning can be compared to long existing government and quasi government institutions. The waste of monies and professional talent are well known. The quality of care per dollar spent would be intolerable in a private institution.

Voluntary hospital planning has worked and can work to provide good quality care. To date there has been a glaring lack of participation and leadership by the medical profession in this field.

John W. Moses, M.D.

Detroit

It would be a brake to both. Already evidence of this is prevalent. Re: The example set by our English counterparts with their socialistic schemes. English hospital construction is tremendously behind their needs. Recently I had the pleasure of showing a British physician through our hospital. He commented on the newness of our hospital (twenty-five years old) and lamented on the lack of construction in his country (albeit, we are short of beds).

We also see evidence in the use of Hill-Burton funds. These funds have been more available to rural areas with overproduction of facilities than to urban areas with bed shortages.

Again evidence of governmental inequities is seen in V. A. Hospital construction according to political desires rather than needs, with consequent lack of bed occupancy and inability to staff hospitals.

Local medical planning should be left in local hands, based on local needs, local abilities and local medical manpower.

Roger B. Nelson, M.D.

Ann Arbor

If one can assume that the law regarding hospital planning will provide, as proposed, a combination of voluntary planning and legal enforcement of the decisions, it is my opinion that it will result in better quality and greater economy in hospital operations.

Duplication of facilities wherein they are not used to full capacity and surpluses of hospital beds are drains on hospital economy. Society cannot continue to afford increasingly expensive hospital equipment used at partial capacity.

Voluntary planning is wholly dependent on the power of persuasion. Unfortunately, those who disregard the recommendations of these organizations are individuals who do not operate facilities of acceptable quality. The authority of law appears necessary to control this group if the quality of hospital function is to be maintained or upgraded.

Next Forum Question

What do you see as a major medical-health need which will face the residents of Michigan in 1991 (25 years hence)? And what might the medical profession do now towards the reduction or correction of that need?

To some degree this question grows from an address by Paul A. Miller, Ph.D., President of West Virginia University at the 1965 National Conference on Adult Education. He challenged special interest groups not only to alleviate the present needs of society—"but in so doing to impart new needs to it."

Your comments are invited for this challenging June Forum Page. Send your observations to "Forum Page," Michigan Medicine, MSMS, 120 West Saginaw, East Lansing.

The Thrilling Story of "Disparagement Mix"

The "SK&F Psychiatric Reporter" runs a tongue-in-cheek article occasionally about Dr. B. Willder's new lines of cliches for writers.

A recent article, in part, described a visit to the kitchen to watch the preparation of a "Disparagement Mix."

"What's cooking?"

"I've got a whole kettle of *hard cores* cooking. Almost every protocol these days has to have at least one."

"And then there are a whole potful of *parameters*, you've got to have a few of those. For garnish, we recommend a *longitudinal study* and one crisp *crossover*. Then, over the whole thing, a generous sprinkling of *valid, objective* and *significant*."

The article by Author Robert L. Dean goes on with more smiles.

Did You Know That . . .

. . . The AMA maintains 13 councils, 64 committees and six commissions.

Through penetrating search, thorough investigation and careful analysis of medical and related facts, the AMA makes one of its most vital contributions to medicine. In its constant effort to further medical knowledge, the Association gathers a vast amount of data on new products, new findings, and new methods—correlating, evaluating and summarizing it—and then reporting the findings to members.

Scientific councils and committees, each composed of physicians living in different parts of the country who are expert in the assigned field of responsibility, work with the aid of full-time headquarters personnel. More than 800 physicians, working without remuneration serve on these councils and committees.

The Mediatric Age:

There is a growing senescent body of people who —either from lack of motivation, or as a result of surgery, trauma, or extended illness—are on their way to malignant inactivity...

The Mediatric Age:

Unfortunately, there is no cure. But there are, largely through your own interest and direction, ways to help them back to a more active and useful life. There are medicines, too, designed to help. One such has proved useful in clinical practice:

"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging . . . This therapy resulted in improvement of 75 per cent of the patients . . ."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

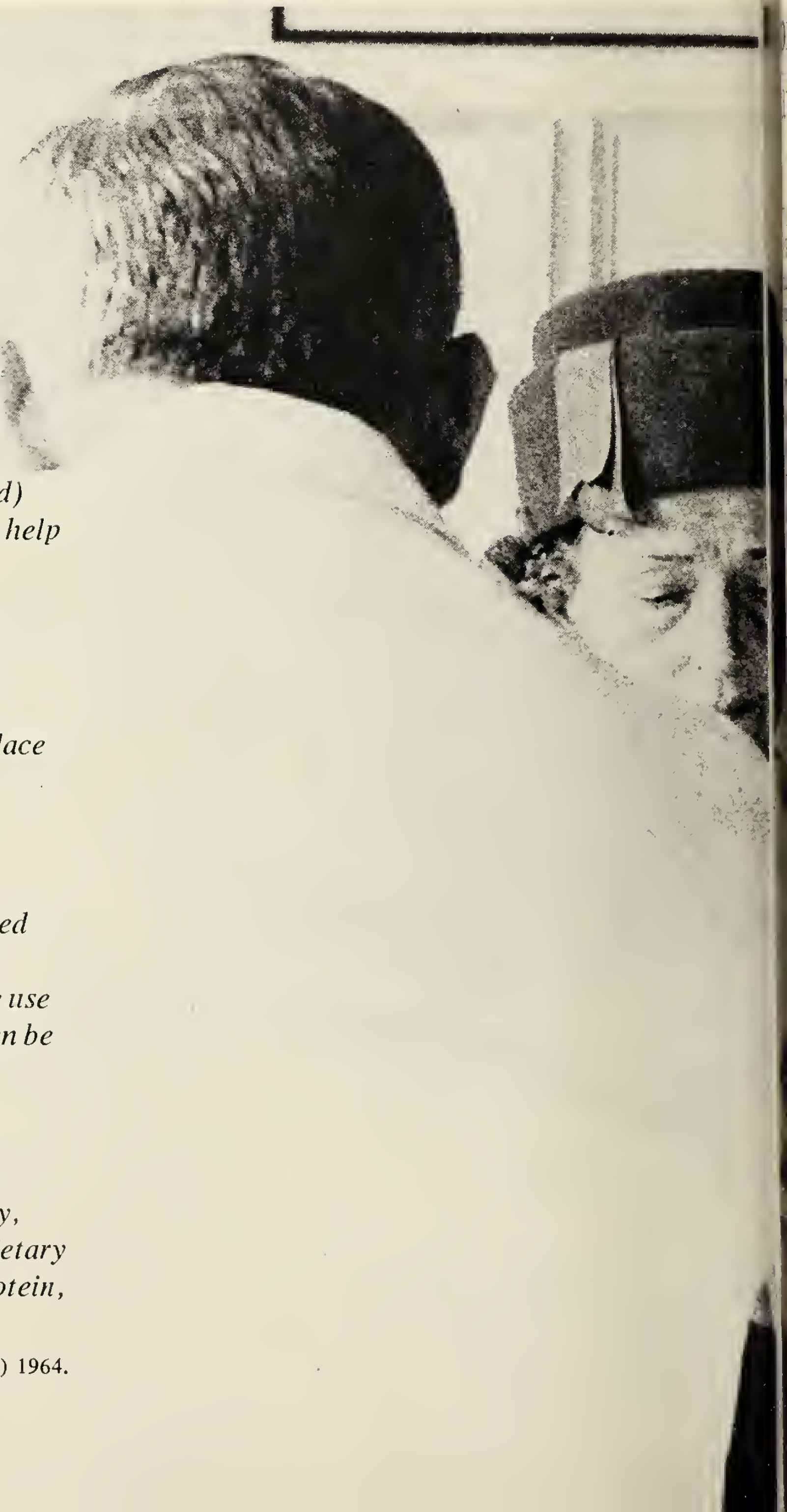
Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied . . . The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.



Mediatric®

Designed for the "metabolically spent"

Nutritional reinforcement for those who can't – or won't – eat properly…balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes…mild antidepressant for a gentle "mood" uplift…

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MEDIATRIC also provides *nutritional reinforcement–blood-building factors and vitamin supplementation.* It contributes a *gentle "mood" uplift* through methamphetamine HCl.

Three different dosage forms–Liquid, Tablets, and Capsules–offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

Conjugated estrogens-equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

Conjugated estrogens-equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic	30.0 mg.
Methamphetamine HCl	1.0 mg.

Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period–Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

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New Committee to Study Education Of Personnel in Health Field

The education and training of health service workers is a big subject now under study by a new MSMS Committee.

The committee is an outgrowth of Resolution 20 adopted by the 1965 House of Delegates. The Council referred the resolution for possible implementation to the MSMS Education Liaison Committee. That committee of physicians and the three medical school deans, chaired by Councilor Don Marshall, M.D., of Kalamazoo, studied the resolution. The Committee observed that "it would be highly appropriate and desirable for MSMS to take a sponsoring role in a study of the total needs for health manpower in Michigan and to consider present and potential training programs at college and universities and also at community colleges."

The Education Liaison Committee recommended that The Council appoint a subcommittee to carry out the intentions of Resolution 20. The Council concurred.

Chairman of the new MSMS Committee is H. J. Meier, M.D., Coldwater, a former Councilor and a former chairman of The Council. Serving with him will be Wm. G. Birch, M.D., Kalamazoo; J. B. Rowe, M.D., Flint; Harry A. Towsley, M.D.; and the three deans or their representatives.

The committee will work under the guidance of its parent committee, the Education Liaison Committee.

Sees Training Trends In Health Manpower

Observations by a nationally-known health career expert before a federal health manpower conference are being studied by the new MSMS committee dealing with the education and training of health service workers.

"Trends in the training of health service workers are developing as a direct response of changes in social and educational patterns and health service practices."

So stated Robert E. Kinsinger, director of the Community College Health Careers Project of the University of the State of New York, in his address February 15 before the Washington, D. C., conference sponsored by HEW.

Mr. Kinsinger identified these trends that are influencing the training of health personnel:

1. The trend to broaden the health team to include many more persons in addition to the doctor, dentist, nurse.
2. A trend to transfer training responsibilities from clinical agencies to educational institutions.
3. A trend for persons trained as nurses, laboratory technologists, etc., to function as full-time college instructors.
4. A trend toward interagency and multidiscipline planning for education and training in the health field.
5. The trend of community colleges to develop a "core curriculum" for health service technicians so students can obtain the similar basic knowledge before declaring a specific career interest.
6. Trends to stretch instructional talent by using television, programmed instruction, etc.
7. A trend to provide continuing education opportunities for school counselors to learn more about the present 200 separate health occupations.
8. The trends of high school cooperative education efforts to lead students directly into employment at the aide and practical-assistant level.
9. A trend away from the uncoordinated establishment of on-the-job-training training programs by clinical agencies.
10. A growing concern for competent teachers, to help move some of talented health service personnel into teacher-training programs.

MSMS Recharters County Societies

The Michigan State Medical Society, midway in its year of celebrating its Centennial, hopes to recharter each of its 55 component medical societies. Recognition can be given the great contribution of each of the component societies to the public welfare by means of a rechartering ceremony.

The presentation of the new charter, to be presented by MSMS, should be scheduled as part of a regular meeting of the medical society. In addition, the County Medical Society may expand the ceremony to include certain historic observations about the County Medical Society, and possibly some of its important personages.

An official of MSMS will make the actual presentation of the new charter.

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.

ABBOTT

mood elevation

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

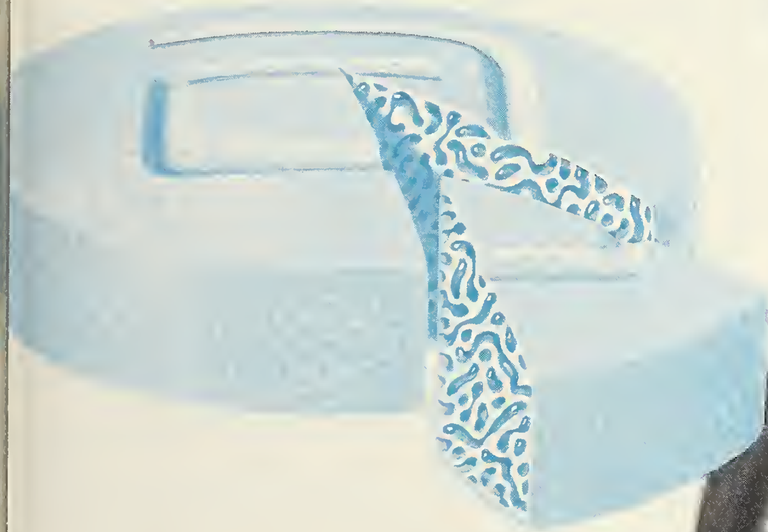
Calms anxieties; controls compulsive eating.

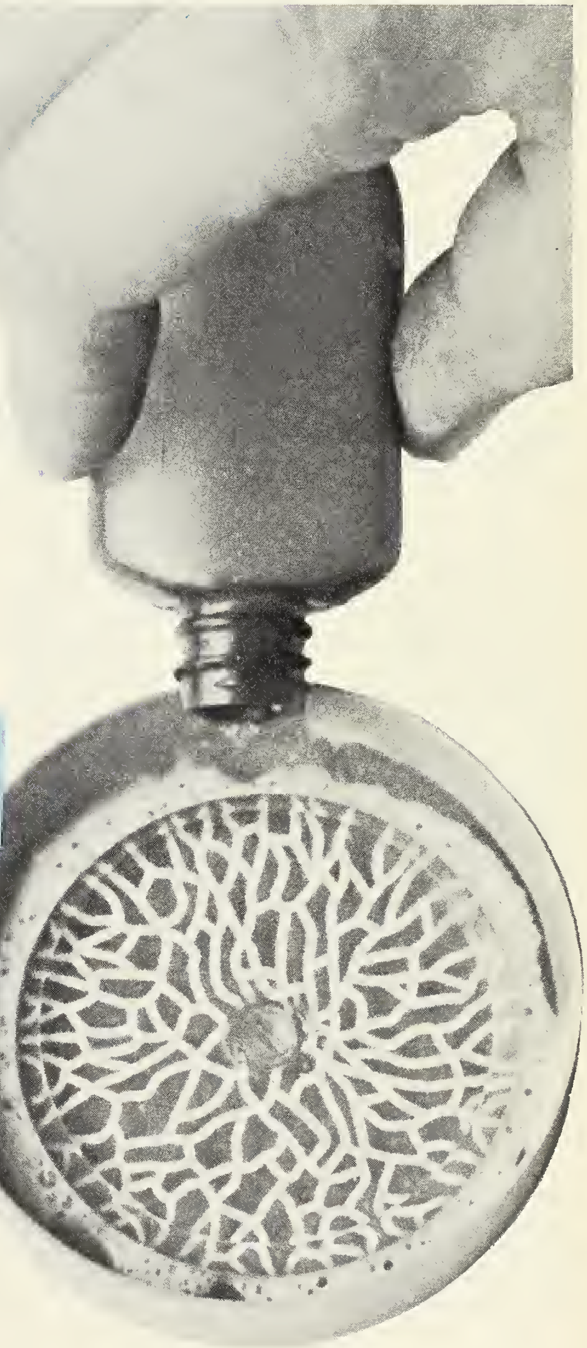
Desbutal Gradumet provides 2 drugs in 2 tablet sections, combined back to back to form a single tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contains Nembutal® (pentobarbital) to calm the patient and counteract any excessive stimulation.

Both drugs are released in an effective dosage ratio throughout the day.

controlled release

Not all long-release vehicles are the same. Here is why the Gradumet is different and what it means for your overweight patients.





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ly one factor common to every patient: gastro-
testinal fluid. There is no dependence on enteric
atings, enzymes, motility, or an "ideal" ion con-
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Your patients get a measured amount of medi-
tion, moment by moment, throughout the day.
They are not subjected to ups and downs of
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patient . . . or to erratic release in the same
tient from day to day.

**hat's why the Gradumet provides
ontrolled-release as well as
ng release.**

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

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Methamphetamine Hydrochloride in Long-Release Dose Form

5 mg.

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15 mg.

DESBUTAL 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium

Front

Side

DESBUTAL 15 Gradum

15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

Front

Side

samples available

Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.

Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

As an anorectic in treatment of obesity, also to counteract anxiety and mild depression

Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed, often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals

A single Gradumet tablet in the morning provides all-day appetite control

Desbutal 10 contains 10 mg of methamphetamine hydrochloride and 60 mg of pentobarbital sodium. Desbutal 15 contains 15 mg of methamphetamine hydrochloride and 90 mg of pentobarbital sodium. In bottles of 100 and 500

Sucaryl Brand **Sweeteners**

A proven aid to weight control—

For use in beverages and foods —stable to heat

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—in tablets and liquid—

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Press out tablets from this side

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For:

Directions:

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economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal ar contraindicated in patients taking a monoamin oxidase inhibitor.

PRECAUTIONS: Use with caution in patients wit hypertension, cardiovascular disease, hyperthy roidism, old age, or those sensitive to sympatho mimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,44
Sucaryl—Abbott brand of low and non-caloric sweeteners.

601060

Abstract of MSMS Council Meeting

Meeting of February 2, 1966

966 ANNUAL SESSION

The Council appointed Oliver B. McGillicuddy, M.D., General Chairman of Arrangements, and at its next ıeeting will appoint a local chairman of arrangements from Grand Rapids. The Council also accepted an offer om the Parke-Davis Company to donate to MSMS a set of four History of Medicine paintings in observance of ıe centennial year of the pharmaceutical firm.

ISTRIBUTION OF MSMS MICHIGAN UNIFORM FEE SCHEDULE

The Council authorized that the Michigan Osteopathic Association be permitted to purchase copies of the lichigan Uniform Fee Schedule for distribution to their membership.

966 OFFICERS CONFERENCE

The Council authorized plans for the Conference to be held on February 25-26 at the Wayne County Medical ociety Building in Detroit.

PPOINTMENT OF EIGHTH MSMS DELEGATE TO THE AMERICAN MEDICAL ASSOCIATION

Because of the growth of MSMS membership it is now entitled to an eighth delegate to the AMA and The ouncil appointed Ralph R. Cooper, M.D., as MSMS delegate to the AMA for the 1966 term. The MSMS House f Delegates will elect in September, 1966, an eighth delegate and an alternate delegate for the regular term eginning January 1, 1967.

Upon the advice of Legal Counsel, The Council referred to the Constitution and Bylaws Committee the queson of clarifying the Bylaws regarding the appointment of an additional delegate, so that the method of electing dditional delegates to the AMA is clearly established.

EPRESENTATIVES TO MEETINGS

The Council appointed representatives from MSMS to attend the AMA Legal Conference on Medicare Laws, lospital-Physician Relations and the AMA Conference on Mental Health in Chicago.

PPOINTMENTS

The Council, at the request of the Michigan Cancer Coordinating Committee, appointed M.D. members of ıe Cancer Coordinating Committee to the MSMS Committee on Cancer.

The Council also reappointed R. W. Teed, M.D., as delegate to the Michigan Health Council for 1966 and ppointed R. E. Rice, M.D., of Greenville as alternate delegate.

The Council received the information that J. M. Dorsey, Jr., M.D., of Birmingham had accepted the chairıanship of the MSMS Child Welfare Committee.

UDICIAL COMMISSION

Secretary Wiley reported to The Council that the organizational meeting of the Judicial Commission had een held, at which the following officers of the Commission were elected: Chairman—Donald M. Sweeny, Jr., I.D.; Vice-Chairman—Harold A. Furlong, M.D.; Secretary—Carl B. Beeman, M.D.

UIDES TO RELATIONSHIPS BETWEEN MEDICAL SOCIETIES AND VOLUNTARY HEALTH AGENCIES

Upon recommendation of the County Societies Committee, The Council authorized that a six-page guide be ppropriately duplicated and distributed by MSMS to all officers of record of all component medical societies.

OLICY STATEMENT RE SEPARATE BILLING BY SPECIALISTS

Upon recommendation of the County Societies Committee, The Council reaffirmed and emphasized its policy upporting separate billing for the professional aspect of radiology, anesthesiology, pathology, and physiatry ervices, and will notify the membership through appropriate MSMS publications.

Further, The Council adopted the following statement as recommended by the Detroit Roentgen Ray and adium Society: "Hospital-based radiologists are engaged in the practice of medicine. The fees for the service f such specialists shall not be merged with hospital charges. The charges for the services of such specialists shall e established, billed and collected by the medical specialists in the same manner as are the fees of other hysicians."

LECTIONS AND APPOINTMENTS

At this, the Annual Meeting of The Council, the following were elected to office: Secretary D. Bruce Wiley, I.D., re-elected; Treasurer Wm. A. Hyland, M.D., re-elected; Scientific Editor George H. Lowrey, M.D., Ann rbor.

Hugh W. Brenneman was reappointed as Executive Director and Warren F. Tryloff was appointed as Assoiate Executive Director.

ANDIDATE FOR AMA OFFICE

The Council endorsed and supported George W. Slagle, M.D., to run for the office of Trustee of the Amercan Medical Association.

(Continued on Next Page)

Medicine-Religion Workshop, April 13

The members of all component medical society committees on medicine and religion are cordially invited to a Medicine and Religion Workshop sponsored by the Michigan State Medical Society, April 13. The event will be held at the MSMS Headquarters in East Lansing from 10:30 a.m. to 3:30 p.m.

"We believe this will be a profitable session offering the committees the opportunity to exchange valuable information of mutual benefit," declares Richard L. Rapport, M.D., of Flint, chairman of the sponsoring MSMS Committee on Medicine and Religion.

An appeal is made by Doctor Rapport "that eve component society committee will be well represented."

The morning will feature an address by Paul McCleave, LL.D., director of the AMA Departmen of Medicine and Religion, Chicago. The count chairmen will report on progress and learn about ne films and other resource materials.

After luncheon and guest speakers, the physicia will meet in roundtable situations to discuss program public relations, etc.

A highlight of the afternoon will be a symposiu between Winslow G. Fox, M.D., Chairman of th Washtenaw County Medical Society Medicine an Religion Committee; Ralph Parvin, past president o the Ann Arbor Ministerial Association, and Re Donald Young, Episcopal Chaplain, Ann Arbor.

ABSTRACT OF MSMS COUNCIL MEETING/continued

STAFF ADDITION FOR MEDICAL CARE ACTIVITY

Upon recommendation of the Advisory Committee to the Executive Director, following a search and interview of candidates, The Council authorized the employment of Mr. Herbert Mehler as the new MSMS employe responsible for MSMS activities in the governmental medical care program area.

REPORT OF MICHIGAN MEDICAL SERVICE

President Sidney Adler, M.D., reviewed items concerning (a) National Association of Blue Shield Plans, (b Evaluation of prepaid medical services, and (c) Medicare status.

Methodist Hospital Graduate Medical Center
Indianapolis, Indiana

Invites Practicing Physicians to Attend a Graduate Course on

ALLERGIC DISEASE AND IMMUNE MECHANISM

May 20, 21 and 22, 1966

This course will cover the field of allergy from a practical viewpoint. Demonstrations of proper skin testing techniques and methods of treatment will be included.

The registration fee ($35.00) will include a book which will cover the practical care of allergic disease. The entire course is geared to help the practicing physician better care for the allergic patient. The book will contain all the lectures in detail, as well as aspects which cannot be completely covered within a few days.

The lectures will be supplemented by Kodachrome studies and round table discussions with question and answer periods.

The program is approved for 15 hours credit in Category I by the American Academy of General Practice.

For further information write:

Department of Medical Education
Methodist Hospital Graduate Medical Center
Indianapolis, Indiana 46207

"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.

BAYER
ASPIRIN
Fast Pain Relief
ORANGE FLAVORED
BAYER
ASPIRIN
CHILDREN
50 TABLETS

WAYNE STATE MEDICAL ALUMNI ANNOUNCE—

1966 Clinic Day & Alum

May 4

The Wayne State University School of Medicine Alumni Association will present their 98th Annual Clinical Program and Alumni Reunion Banquet on Wednesday, May 4, in the Sheraton-Cadillac Hotel, Detroit.

The day's events will include morning and afternoon scientific programs, Alumni Association meetings, presentation of Golden Anniversary Diplomas to members of the Class of 1916, and the awarding of citations and other honors. The Dinner Dance will highlight social events of the Reunion.

Alumni and other doctors of medicine are cordially invited to participate in the Clinical Program. Contact Alumni House, Wayne State University, if you wish banquet reservations. Requests for room reservations at the Sheraton-Cadillac Hotel should mention the Wayne State Medical Alumni Clinic Day.

Sheraton-Cadillac Hotel

●

Detroit

Registration Opens: 8 a.m.

A DISTINGUISHED SERVICE CITATION will be awarded to City-County Health Commissioner John J. Hanlon, M.D. A 1941 graduate of the School of Medicine, Dr. Hanlon is presently chairman of its department of community medicine. The Citation is in recognition of his outstanding professional contributions.

Dr. Hanlon

Dr. Jocz

ALUMNI ASSOCIATION PRESIDENT Marion W. Jocz, M.D., will be chairman of the morning session of the Scientific Program. Dr. Jocz is Corporate Medical Director, Chrysler Corporation and holds a clinical associate professorship in the School of Medicine.

TOASTMASTER at the Reunion Banquet will be Mr. Donald M. D. Thurber, president of Public Relations Counselors, Inc., and a member of the State Board of Education. Mr. Thurber is also Regent-Emeritus of The University of Michigan.

Mr. Thurber

union

1868

SCIENTIFIC PROGRAM

Morning Session

ON PAUL JONES, M.D.: "Clinical and Etiologic Factors in Alcoholic iver Disease." Dr. Jones, who received his medical degree from the Univer- ity of Michigan, is assistant professor of medicine and chief, department of astroenterology, in the Wayne State School of Medicine.

ARRELL E. STATZER, M.D.: "Present and Future Trends in the Anti- vulants." A specialist in obstetrics and gynecology, Dr. Statzer holds ap- ointments at Harper Hospital, Detroit General Hospital and Hutzel Hospital. recipient of the medical degree from the University of Illinois, Dr. Statzer s also a clinical instructor in the Wayne State School of Medicine.

OBERT L. JACKSON, M.D.: "Management of the Child with Diabetes." r. Jackson is a graduate of the University of Michigan Medical School. ince 1954, he has been professor and chairman of the department of ediatrics at the University of Missouri School of Medicine. In addition o juvenile diabetes, Dr. Jackson has done research in the field of infant nd child metabolism and nutrition. His studies in pediatrics have been ublished widely.

Dr. Jones

Dr. Statzer

Dr. Jackson

Afternoon Session

JOHN STIRLING MEYER, M.D.: "Current Concepts of Treatment at the Wayne Center for Cerebrovascular Disease." A member of President Johnson's Commission on Heart Disease, Cancer and Stroke, Dr. Meyer, with the help of colleagues, has developed new methods for measuring cerebral blood flow and brain chemistry in the living patient. Recipient of the M.D. degree from McGill University, Dr. Meyer is professor and chairman of the department of neurology at Wayne State.

GEORGE D. ZUIDEMA, M.D.: "Problems in the Management of Portal Hypertension." A graduate of the Johns Hopkins University School of Medicine, Dr. Zuidema is chairman of its department of surgery and is surgeon in chief at the Johns Hopkins Hospital. In addition to numerous professional memberships, Dr. Zuidema has held several consulting positions, including work on missile and aerospace projects for private industry and the Air Force.

ROBERT G. HOYER: "Medicare and the Medical Profession." Mr. Hoyer is a supervisory social insurance specialist in the new Bureau of Health Insurance of the Social Security Administration, Baltimore. A graduate of the University of Notre Dame, he has been with the Social Security Administration since 1954.

Dr. Meyer

Dr. Zuidema

Mr. Hoyer

Anatomy of
Low Back Pain #1
the sedentary life
is often the seat of
low back pain

The human spine is not engineered prolonged sitting at desks, pianos, t writers and drafting boards. The stre set up by the heavy, forward-tilted h and trunk, balanced precariously or insufficient base, result in strain of dorsal musculature, particularly at low lumbar level.

The unusual muscle-relaxant and a gesic properties of 'Soma' make it es cially useful in the treatment of low b sprains and strains. 'Soma' is wic prescribed ☐ **to relieve pain** ☐ **to re muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for managemer muscle spasm, pain, and stiffness in a variet inflammatory, traumatic, and degenerative mu loskeletal conditions. It also may act to norm motor activity in certain neurologic disturban

Contraindications: Allergic or idiosyncratic r tions to carisoprodol.

Precautions: 'Soma', like other central nen system depressants, should be used with cau in patients with known propensity for taking cessive quantities of drugs and in patients known sensitivity to compounds of similar che cal structure, e.g., meprobamate.

Side Effects: The only side effect reported with frequency is sleepiness, usually on higher t recommended doses. An occasional patient not tolerate carisoprodol because of an indivi reaction, such as a sensation of weakness. O rarely observed reactions have included dizzin ataxia, tremor, agitation, irritability, headache, crease in eosinophil count, flushing of face, gastrointestinal symptoms.

One instance each of pancytopenia and le penia, occurring when carisoprodol was adr istered with other drugs, has been reported, as an instance of fixed drug eruption with carisopr and subsequent cross reaction to meprobam Rare allergic reactions, usually mild, have inclu one case each of anaphylactoid reaction with r shock and angioneurotic edema with respira difficulty, both reversed with appropriate ther In cases of allergic or hypersensitivity reacti carisoprodol should be discontinued and appro ate therapy initiated. Suicidal attempts may duce coma and/or mild shock and respira depression.

Dosage: Usual adult dose is one 350 mg. ta three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tabl and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

**for the relief
of low back
sprains and strain**

SOMA

(CARISOPRODO

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(Continued on Next Page)

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The U. S. Department of Labor researchers came up with these statistics: In the 20-24 age group, the average worker will probably change his job 6.6 times during his lifetime. Those in the 25-34 age group will change jobs 4.8 times. Even those in the 45-54 group can expect to change jobs 1.4 times before retirement. (Executives' Digest, 11/65, Cambridge Associates, Inc.)

101st MSMS Annual Session
Grand Rapids
September 27-28-29-30,1966

All activities, except luncheon meetings, will be concentrated at the Grand Rapids Civic Auditorium. Outstanding scientific panel discussion, lectures, and discussion workshops. Excellent exhibits. Auxiliary Art Show. M.D. screening examinations. Annual banquet, etc.

YOU'RE INVITED
CONFERENCE ON MEDICAL
NEWS WRITING
MAY 5, KELLOGG CENTER, MSU

MEDISCENE

April 6—Genesee County Medical Society Cancer Day, Hurley, Flint

April 13—Annual Meeting, Michigan League for Nursing, Hurley Hospital, Flint

April 18-22—Michigan Nurses Association, Spring Conference, Civic Center, Lansing

April 24—Michigan State Medical Assistants Society, 9th Annual Educational Seminar, Empire House Motel, Bay City

May 2-7—Western Michigan Health Fair, Muskegon

May 5—Conference on Medical Reporting, Kellogg Center, East Lansing

May 11-13—Michigan Public Health Association Annual Meeting, Pick-Fort Shelby Hotel, Detroit

May 13-14—Michigan Kidney Foundation Medical Symposium, David Whitney House, Detroit

May 14-15—Michigan Association of the Professions Congress, Pontchartrain Hotel, Detroit

May 15-21—Michigan Week

June 4-5—Seminar on Marriage Counseling, Boyne Highlands Inn, Harbor Springs

June 17-18—Upper Peninsula Medical Society Annual Meeting, Iron Mountain

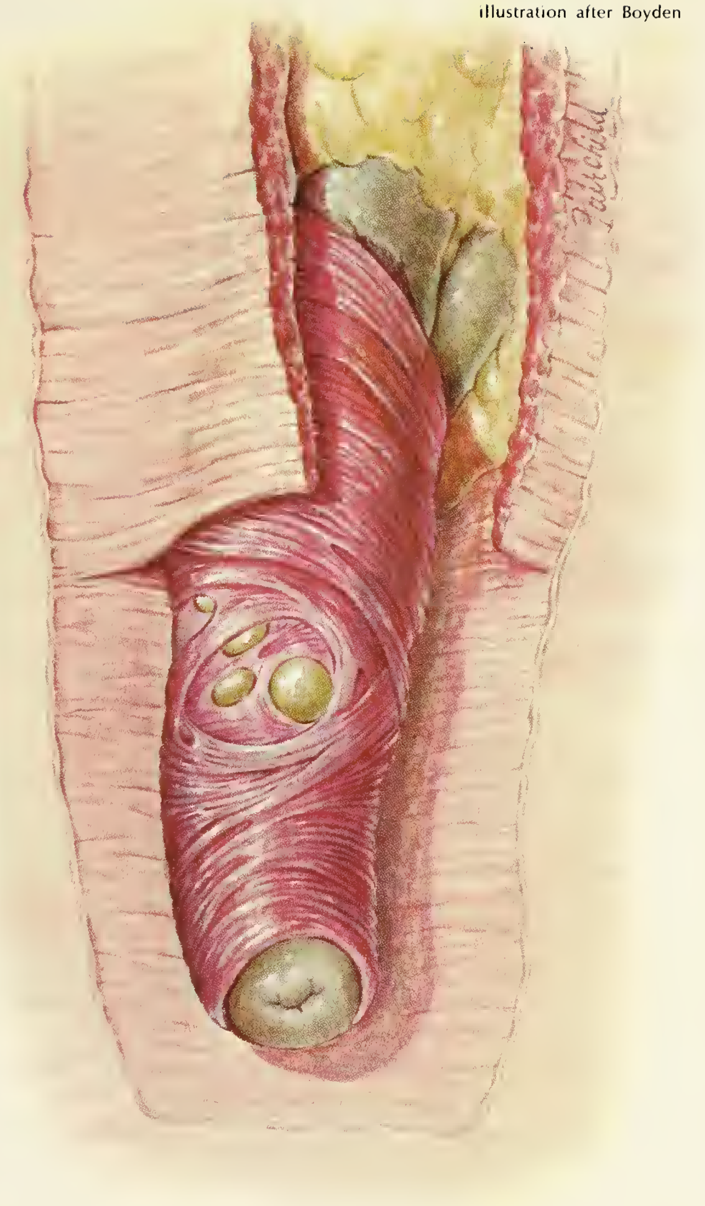
June 22-25—Michigan Association for Retarded Children Conference, Northern Michigan University, Marquette

Sept. 12-16—Michigan Nurses Association, Conference for Operating Room Nurses, Kellogg Center, East Lansing

Sept. 25-27—Michigan State Medical Society House of Delegates, Pantlind Hotel, Grand Rapids

Sept. 27-30—Michigan State Medical Society Annual Scientific Session, Civic Center, Grand Rapids

Illustration after Boyden



HOW IMPORTANT IS THIS
IN YOUR DIAGNOSES OF SMOOTH MUSCLE SPASM?

1966 Philips Roxane, Inc.

PERHAPS VERY IMPORTANT

The sphincter of Oddi is made up primarily of smooth muscle fibers. It permits the gall bladder to fill, regulates the flow of bile and pancreatic enzymes and in dysfunction is a primary cause of Biliary Dyskinesia. The sphincter of Oddi is but one of five major foci of smooth muscle spasm where SPACOLIN® (Alverine citrate) acts directly with rapid onset and long duration. No neurotropic side effects because Spacolin is a musculotropic counter-spasmodic unrelated to atropine or atropine-like drugs. Spacolin is not contraindicated in prostatic hypertrophy.

SPACOLIN® **(Alverine citrate)**

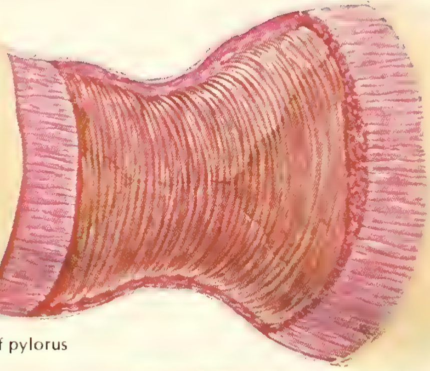
Each tablet contains: Alverine citrate . . . . 120 mg.

INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

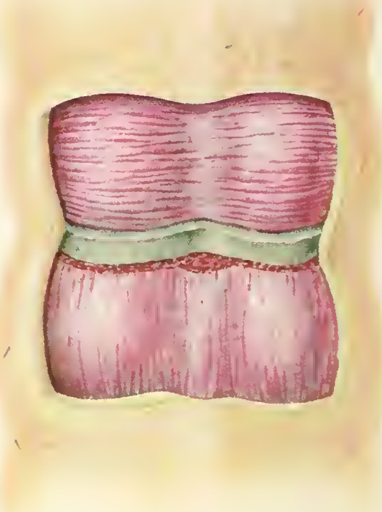
*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

PHILIPS ROXANE LABORATORIES Division of Philips Roxane, Inc.,
Columbus, Ohio

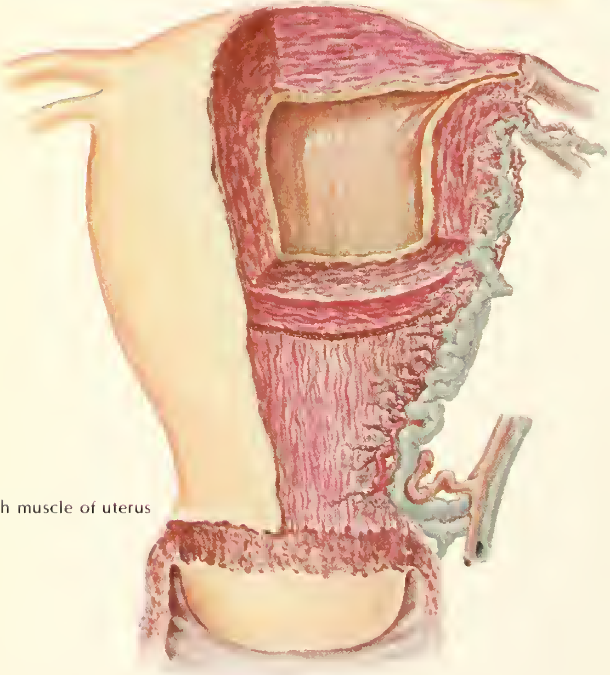
smooth muscle sphincter of Oddi



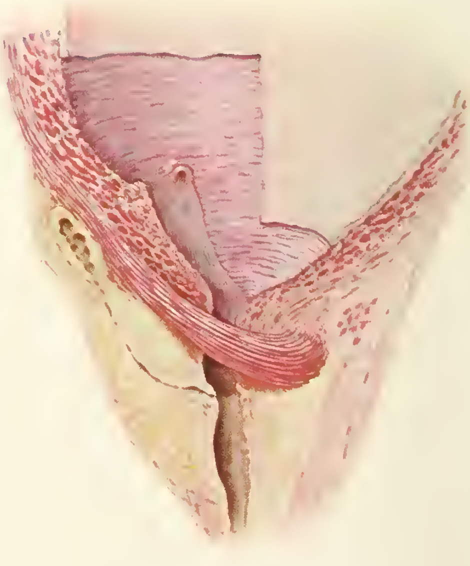
smooth muscle of pylorus



smooth muscle of colon



smooth muscle of uterus



smooth muscle of urinary bladder

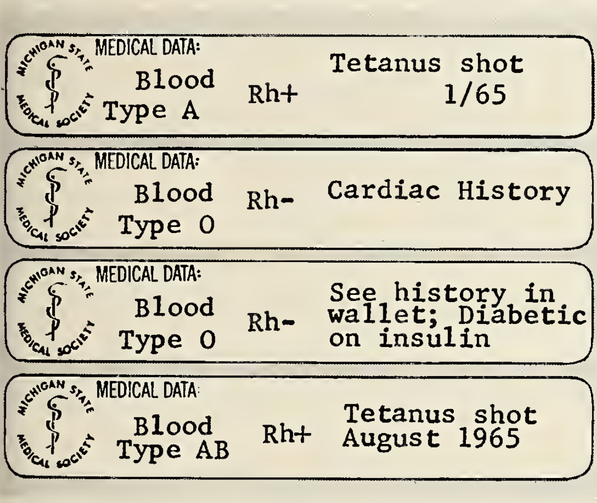
H/D Resolution 46 Committee Is Named

The MSMS Council has appointed Paul W. Gikas, M.D., Ann Arbor, as chairman of a special committee to meet with medical directors in the automotive industry to explore possible approaches to the implementation of Resolution 46 from the 1965 House of Delegates. The Resolution authorized such a committee to work toward advanced safety features in car design. Committee members include G. Donald Albers, M.D., Grand Rapids; Franklin V. Wade, M.D., Flint; and MSMS President-Elect C. Allen Payne, M.D., Grand Rapids.

Named Vice-Chairman

D. Bonta Hiscoe, M.D., Lansing, has been elected vice-chairman of the Michigan Health Facilities Planning Council.

Doctor Hiscoe represents MSMS on the Council, a division of the voluntary Hospital Research and Educational Reserve of Michigan, Inc.



MEDICAL DATA: Blood Type A Rh+ Tetanus shot 1/65

MEDICAL DATA: Blood Type O Rh- Cardiac History

MEDICAL DATA: Blood Type O Rh- See history in wallet; Diabetic on insulin

MEDICAL DATA: Blood Type AB Rh+ Tetanus shot August 1965

WRITE MSMS FOR MORE "MEDI-LABELS"

MSMS members are urged to provide their patients with medical data stickers for their new drivers licenses. The stickers, developed by MSMS and approved by the Secretary of State, can be used to indicate such valuable information as blood type, tetanus immunization dates, allergies, contact lenses, etc.

The medi-labels are available, free of charge, by writing to Stickers, MSMS, 120 West Saginaw, East Lansing.

Delegates to AMA

Following is the list of MSMS delegates and alternate delegates to the AMA, as elected by the MSMS House of Delegates:

Delegates (in alphabetical order according to term):

Sidney Adler, M.D., Detroit; Term: January 1965 through December 1966;

George W. Slagle, M.D., Battle Creek; January 1965 through December 1966;

Donald N. Sweeny, Jr., M.D., Detroit; January 1965 through December 1966;

John R. Heidenreich, M.D., Daggett; January 1965 through December 1967;

William A. Hyland, M.D., Chairman, Grand Rapids; January 1965 through December 1967;

Luther R. Leader, M.D., Birmingham; January 1965 through December 1967;

Robert E. Rice, M.D., Greenville; January 1965 through December 1967.

Alternate Delegates (in order of seniority):

1. Ralph R. Cooper, M.D., Detroit; January 1965 through December 1966;
2. Oliver B. McGillicuddy, M.D., Lansing; January 1965 through December 1966;
3. Wyman C. C. Cole, Sr., M.D., Detroit; January 1965 through December 1967;
4. Bradley M. Harris, M.D., Ypsilanti; January 1965 through December 1967;
5. Otto K. Engelke, M.D., Ann Arbor; January 1965 through December 1967;
6. Gilbert B. Saltonstall, M.D., Charlevoix; January 1965 through December 1967;
7. Joseph A. Witter, M.D., Highland Park; January 1965 through December 1966.

50 Years Ago . . .

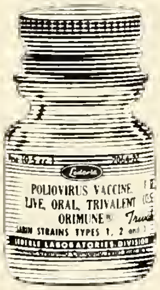
Our advertising pages make the monthly MSMS publication possible. They are an absolute necessity unless we wish to increase our subscription price to $3.00. Repeatedly have we discussed this subject; once more do we urge that you:

1. Read every advertisement.
2. Patronize every advertiser in preference to all the other firms.
3. Let the advertiser know that you favor him.
4. Endeavor to induce others to utilize advertising space in your publication.

This request must receive your continued interest and co-operation and equals in importance all the others.

—MSMS Journal
January, 1916

Doctor...two important Lederle products for routine office procedures



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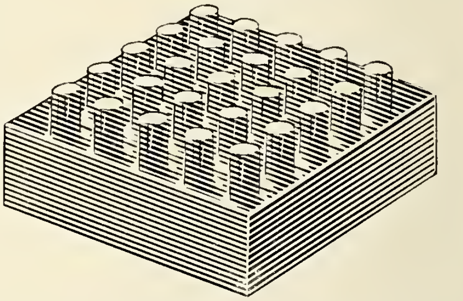
TRIVALENT

SABIN STRAINS, TYPES 1, 2 and 3

Fast, simple administration—and economy for the patient—make the new 0.5 cc single-dose vial of ORIMUNE Trivalent ideal for private practice. (Packaged 5 to a box with 5 sterilized disposable droppers for your convenience).
(Also available in 2 cc and 2 drop dosage forms).
Only 2 doses required for complete, initial immunization for patients more than a year old.

Effectiveness—may be expected to confer active immunity against all three types of poliovirus infection in at least ninety percent of susceptibles only if given at full dosage, as directed. No characteristic side effects have been reported. There are, however, certain contraindications. These are, broadly: acute illness, conditions which may adversely affect immune response, and advanced debilitated states. In these, vaccination should be postponed until after recovery.
In infants vaccination should not be commenced before the sixth week of life. Do not give to patients with viral disease, or if there is persistent diarrhea or vomiting. ORIMUNE and live virus measles vaccine should be given separately.
Dosage—initial immunization: two doses each given orally at least 8 weeks apart. (Give a third dose to infants at 10-12 months). Booster immunization: one dose, given orally. See package literature for full directions.



simplifies routine screening

TUBERCULIN, TINE TEST

(Rosenthal) Lederle

Swab • Uncap • Press • Discard

Comparable in accuracy and reliability to older standard intradermal tests*, but faster and easier to use. Since TINE TEST is relatively painless it should receive greater patient acceptance. Results are read at 48-72 hours. The self-contained, completely disposable unit requires no refrigeration and is stable for two years.
Side effects are possible but rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. Available in boxes of 5 (new individually-capped unit); cartons of 25.

*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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In Memoriam

Walter J. Bien, M.D., Coldwater

Walter J. Bien, M.D., died February 19, at the Health Center in Coldwater, after being in a coma for nearly a year as the result of a motor accident. He was 77 years old.

Doctor Bien was born in Rochester, New York, and received his medical degree from the University of Michigan Medical School. He practiced as an eye, nose and throat specialist in Coldwater for 45 years. At the time of his death, Doctor Bien was connected with the staff at Coldwater State Home and Training School.

During World War I Doctor Bien served as a lieutenant in the U.S. Medical Corps.

Doctor Bien was a Life Member of the Michigan State Medical Society.

Henry S. Brown, M.D., Detroit

Henry S. Brown, M.D., former medical director of the Michigan Bell Telephone Company, died Februrary 11 in St. Mary's Hospital, Detroit. He was 74.

Born in Providence, Rhode Island, Doctor Brown received his medical degree from Tufts Medical School in 1917. Two years later, he came to Detroit and went into general practice. Before joining Michigan Bell, he served as an industrial surgeon for an insurance company. Doctor Brown joined Michigan Bell in 1924 and became its medical director in 1930. He retired in 1956.

Doctor Brown was a past president of the American College of Physicians and Surgeons and the Industrial Medical Association. He was a member of the International College of Physicians and Surgeons, the American Association of Military Surgeons and the American Public Health Association.

Doctor Brown was a Life Member of the Michigan State Medical Society.

Lawrence P. Hickner, M.D., Bay City

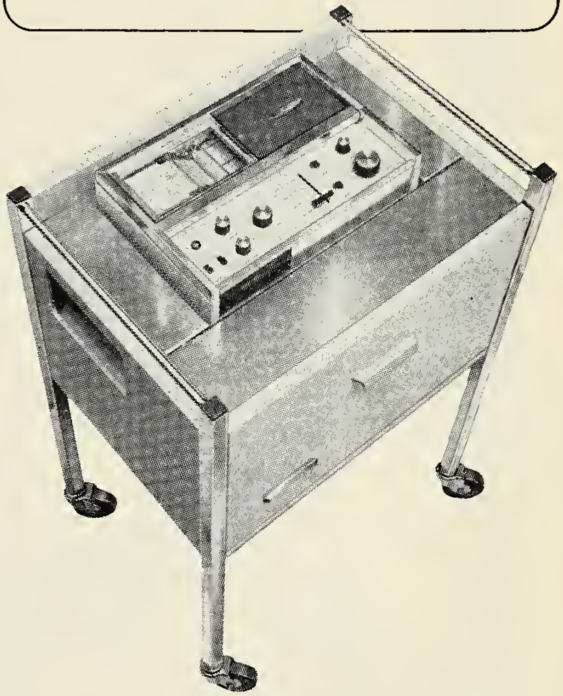
Lawrence P. Hickner, M.D., Bay City psychiatrist, died accidentally of carbon monoxide poisoning on January 25. He was 44 years old. His daughter Mary, 14, was also a victim of the tragedy.

A native of Sheldon, North Dakota, Doctor Hickner received his medical degree from Creighton University, Omaha, Nebraska, in 1947.

Doctor Hickner was affiliated with General Hospital and Mercy Hospital in Bay City, and was a member of the American Psychiatric Association and the Michigan Society for Mental Health.

Doctor Hickner was a veteran of the Korean War.

The dramatically new
Burdick EK 4
Electrocardiograph



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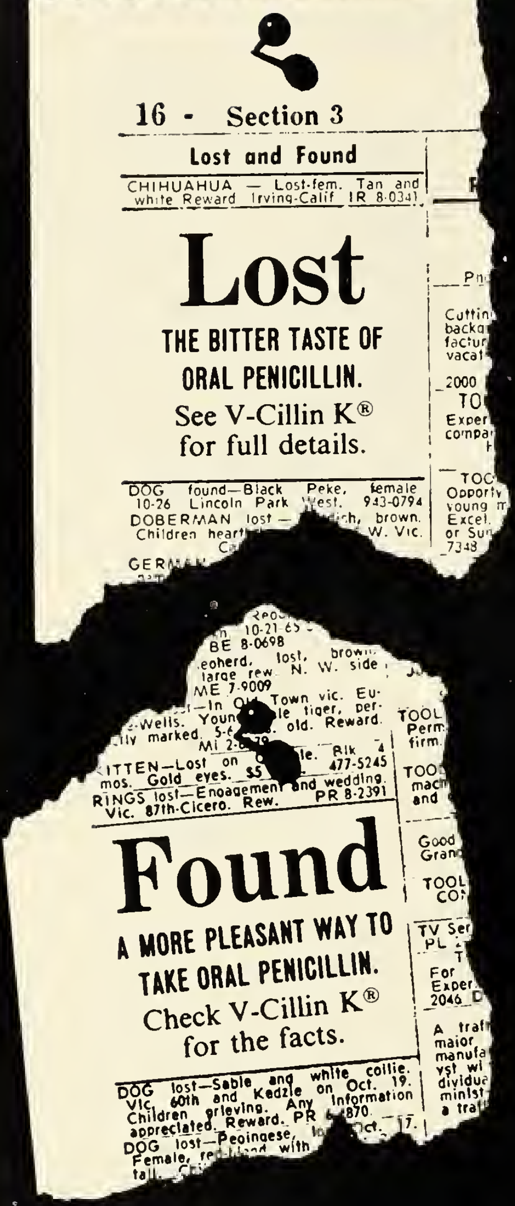

16 - Section 3

Lost and Found

CHIHUAHUA — Lost-fem. Tan and white Reward Irving-Calif IR 8-0341

Lost

THE BITTER TASTE OF ORAL PENICILLIN.

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DOG found—Black Peke, female 10-26 Lincoln Park West. 943-0794
DOBERMAN lost — brown. Children heart W. Vic.
GERM

10-21-65
BE 8-0698
lost, brown N. W. side
ME 7-9009
Town vic. Eu-
Wells. Youn tiger, per- old. Reward.
marked
KITTEN—Lost on Blk 4 mos. Gold eyes. $5 477-5245
RINGS lost—Enoagement and wedding. Vic. 87th-Cicero. Rew. PR 8-2391

Found

A MORE PLEASANT WAY TO TAKE ORAL PENICILLIN.

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DOG lost—Sable and white collie. Vic. 60th and Kedzie on Oct. 19. Children grieving. Any information appreciated. Reward. PR
DOG lost—Peoingese, Female,

Patients won't complain about bitter penicillin taste when you specify V-Cillin K. Here's why: It has a special coating, only one and a half *thousandths* of an inch thick. Because it is designed to dissolve after approximately six seconds, this barrier to bitterness remains on the tablet as it slides past the tongue. When the tablet reaches the stomach, however, the coating has dissolved, and the penicillin is ready for immediate absorption into the bloodstream.
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Supplied: Tablets V-Cillin K, 125 or 250 mg., and V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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ORIGINAL
SCIENTIFIC
ARTICLE

Respiratory And Cardiac Resuscitation

By Thomas R. Kain, M.D.
Gianfranco Dal Santo, M.D.
Both of Detroit

Two sets of circumstances distinguish two types of cardiac arrest. One occurs in the operating room and allied areas where anesthetics and special drugs are administered, and may be designated as *iatrogenic cardiac arrest*. The other occurs chiefly in medical patients in hospital areas, but outside the operating theatre or surgical areas. The arrest in this group is precipitated by the effects of natural disease processes. Usually the facilities and personnel needed for thoracotomy and direct cardiac massage are not available.

* * *

For this latter group the following information and procedure is established.

In 1958, airway obstruction was recognized as the major obstacle for the manual methods. The expired air methods (mouth to mouth or nose artificial respiration) were demonstrated to be superior. While medical and rescue organizations were revising their doctrines to introduce this technique, a manual method was shown to be capable of producing artificial circulation.

In 1960, external thoracic compression was rediscovered as a maneuver which can provide effective circulation without opening the chest. By the rhythmic depression of the lower sternum, the heart of man may be compressed against the spine to pump sufficient blood to produce a palpable pulse and sustain cerebral perfusion to maintain consciousness.

Since 1956 external defibrillation has become commonplace and employs either alternating or direct current. Intracardial injection of epinephrine has been restored, but with a more rational basis along with refinements in the use of vasopressor and alkalinizing drugs.

* * *

Other advances have been made in postresuscitative care (long term resuscitation) e.g., elective tracheotomy, mechanical ventilation, hypothermia. This treatment is carried out in intensive care units where specially trained personnel and equipment are available. Thus, the limited approach to resuscitation of the past has shifted to aggressive maneuvers designed to reverse asphyxia in the myocardium and central nervous system. These measures aim to maintain an unobstructed airway, ventilate the lungs, circulate blood to the brain and heart, restore spontaneous heart beat, defibrillate the ventricles, if required, and limit the sequelae of hypoxia and acidosis.

Judgment must be exerted on the wards and in the emergency room in selecting patients in whom resuscitative measures are to be expended.

Resuscitation should not be instituted on all patients. Whenever, in the judgment of the physician, there is little hope for the establishment of sustained spontaneous cardiac and respiratory action, and when there is no hope for a successful outcome, resuscitation measures should not be instituted nor pursued.

* * *

When there is sudden disappearance of blood pressure and pulse for 15 seconds or more, the diagnosis of cardiac arrest must be assumed. Usually, when respiration ceases, cardiac action will cease in four minutes. It is evident that cardiac action and respiration are interdependent. Efforts have to be carried out to restore both systems.

Management of Resuscitation

Technique of Heart-Lung Resuscitation

A. Artificial respiration[1]

1. Place patient in supine position.
2. Establish a patent and clean airway.
   a. Clean out mouth and pharynx (by swab or suction).
   b. Tilt head back (hyperextension in atlanto-occipital joint).
   c. Lift the jaw (pull chin forward.)
   d. Artificial airway should be used only if the operator has experience in the use of this device.
3. Start pulmonary ventilation.
   a. By mouth to mouth (or nose). It is generally recognized that the expired air of a rescuer is an adequate ventilating gas. The composition of expired air is the essential endowment which makes expired air resuscitation a simple, natural, available, versatile procedure. The concentration of oxygen in expired air depends upon

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oxygen consumption, pulmonary ventilation and oxygen concentration in the inspired air. An average man at rest consumes 300 ml of oxygen per minute and breathes 500 ml of air 15 times per minute. The oxygen concentration in the expired air is 16.5 per cent. By doubling his tidal volume to one liter and breathing 12 times a minute, the oxygen concentration of the expired air will be 18.5 per cent. Similarly, hyperventilation at twice the resting level converts the rescuer's expired CO_2 to 2 per cent, and that of the patient's to a normal 4 per cent. Thus by adequate hyperventilation, the rescuer can easily convert his exhaled air into a suitable resuscitating gas.

The choice between the nasal and oral routes of inflation is not important. Both are generally performed with equal facility by a practiced rescuer. Mouth to nose breathing is essential for the victim with trismus or convulsions, while mouth to mouth must be used when the nose is blocked. In the water, mouth to mouth breathing is easier to carry out.

The frequency of inflation is less essential than the volume delivered to the lungs. The adult patient should receive twice his basal tidal volume at the rate of 12 times per minute. In children 20 times, and in infants 30 times per minute is the recommended rate.

b. By bag and mask or via endotracheal tube or tracheotomy. Respiratory resuscitation by medical personnel is facilitated by portable devices which are designed to: provide an attachment to the patient's upper airway; maintain patency through the mouth, nose and pharynx; inflate the lungs; prevent contamination of the rescuer's mouthpiece by the patient's exhalation; and remove secretions or fluid from the upper airway or stomach.

c. By resuscitator. Several different types of mechanical units are available for resuscitation. The manual resuscitators (Ambu, Pulmonator, etc.) are easy to learn how to use and may be used by mask, via endotracheal tube or tracheostomy.

Further details on resuscitators, manual and automatic, are beyond the scope of this paper and we refer the reader to special literature on the subject.

B. Artificial circulation[2]

Cardiac arrest is the sudden and unexpected cessation of cardiac output. It can occur as total standstill (asystole), ventricular fibrillation, or profound, sudden circulatory collapse, with insufficient cardiac output. In all cases, oxygenation must be reestablished within four minutes or irreversible central nervous system damage will result. Immediate artificial respiration and circulation (cardiac massage must therefore be provided.

When cardiac arrest occurs outside the operatin theatre, external cardiac[3,4] massage is the preferre method. The patient is placed on a firm surfac External massage is performed by positioning of th main weight of the operator above the patient, eithe to the right or left side. The heel of the hand i placed on the lower sternum just cephaled to th xiphoid. The fingers, although over the chest, ar not used for transmission of pressure. This is important in the prevention of rib fractures. The othe hand is placed over the first. Rhythmic thrusts ar now made downward on the sternum at a rate o once a second (60 times per minute). The sternun should be moved 4 or 5 cm toward the thoraci spine with each thrust. Complete relaxation of th hands following each compression should be mad allowing complete expansion of the chest and maximum venous filling of the heart.

For infants and small children,[5] because the liver i located under the xiphoid, external cardiac massag should be done on the middle part of the sternun to avoid rupture of the liver. In infants, only tw or three fingers should be used for the compressio of the sternum; in children up to 10 years of ag the heel of one hand is adequate for sternal compression.

External heart compression is commonly complicated by rib fractures. Jude[4] does not regard thi result as serious unless numerous fractures produc a flail chest, loss of elastic recoil with release o compression, and decreased venous filling. Often th incidence of rib fractures is a result of improper technique in which pressure is applied against the ri cage and not restricted to the lower sternum. Pneumothorax has also been reported and was attribute to previous lung disease or the result of transpleura injections into the heart chamber. This complication is not serious if recognized and treated by underwater catheter drainage. The frequency of thes complications decreases with experience if pressur is applied only to the sternum and should not dete resuscitation.

C. Signs of resuscitation

The skin may lose all its pallor or cyanosis and confirm the circulation of oxygenated blood; frequently the skin remains cold and grey despite the reinstitution of perfusion of the brain. The most significant sign of reversal of asphyxia in the central nervous system is the size of the pupils. Unless pupillary fixation occurred as a result of drugs, the pupils dilate within the first minute of arrested circulation and constrict within the first minute of restoration of cerebral perfusion. Similarly, the pupils lose and regain their reflex response to light as a result of available oxygen in the brain.

Palpation of major pulses during heart compreson is another sign of adequate technique. Early ecovery is characterized by gasping or groaning or wakening, depending upon the anoxic interval.

Failure of the pupils to constrict following heart-lung resuscitation, including cardiotonic, vasopressor nd alkalotic drugs indicates irreversible cerebral amage. Persisting in resuscitative effort is difficult justify.

. Drugs used in cardiac resuscitation

The use of cardiotonic, vasopressor, alkalinizing nd antiarrhythmic drugs is a vital part of cardiac esuscitation in the hospital.

Epinephrine has a well known positive inotropic ffect upon the myocardium and is the most commonly used drug in cardiac arrest. It was observed hat while epinephrine fibrillates the anoxic heart, ts effect upon the reoxygenated atonic arrested heart as to reinitiate spontaneous rhythm and improve he strength of contraction. Jude and others recommend the intraventricular injection of epinephrine n any patient in circulatory arrest whose heart does ot resume evident spontaneous activity within a few minutes of external heart compression. This practice pplies, irrespective of whether the ventricules are in systole or fibrillation. Oxygenation of the myocardium must be insured by heart compression.

The recommended dose of intracardiac epinephrine in cardiac arrest in man varies from 0.1 mg to .5 mg (1:10,000 epinephrine) injected preferably nto the left ventricular heart chamber.

Calcium chloride augments the tonus of the myocardium increasing the force of contraction and the hreshold excitability. Kay and Blalock introduced ts use in the management of cardiac arrest in 1951. The observed increase in rate or the restoration of ardiac contraction induced by calcium chloride in he intact animal is perhaps secondary to the release of catecholamines. In man, the dosage of calcium hloride for intracardiac injection is 1 gm (10 ml. 10 per cent solution).

Norepinephrine has some positive inotropic effect upon the myocardium, and increases the coronary blood flow following peripheral vasoconstriction and does not produce arrhythmia.

Other vasopressors used in cardiac arrest are: ephedrine, phenylephrine, mephentermine and metaraminol.

Procainamide and quinidine are used occasionally o reduce cardiac irritability. Since these drugs depress the myocardium, their effects must be assessed by observation of the electrocardiogram. (Dose of procainamide varies from 150-500 mg.) Digitalis improves myocardial function by slowing the rate and increasing diastolic filling. Digitalization is indicated following cardiac resuscitation if tachycardia persists and is accompanied by hypotension. In the case of heart failure, rapid digitalization with Cedilanid is the choice. The dose varies from 0.8 mg to 1.6 mg.

With the arrest of the circulation or respiratory failure, severe respiratory and metabolic acidosis develop rapidly. As tissue perfusion fails, pH values fall below 7.4, and buffer base to values less than 25 mEq per liter. Catecholamines are released in increased rates but fail to act upon the heart and vessels apparently as a result of the low pH. The heart and peripheral blood vessels dilate. Cardiac rhythm is also impaired as a result of the acidosis as evidenced by deterioration of electrical activity and failure to reinitiate spontaneous rhythm.

To combat the acidosis in patients receiving heart-lung resuscitation a conservative dose schedule would be 44.6 mEq of sodium bicarbonate for each five minutes of inadequate circulation (half dose in child). Sodium lactate is used to treat metabolic acidosis of lesser severity and lesser urgency. THAM (TRIS) another buffer, appears to be an effective agent for the correction of metabolic acidosis associated with cardiac arrest, and its systematic use in such cases is warranted.

Recommended dose is 1 ml per kg of a 0.3-0.5 M THAM solution as an adjunct to other therapeutic measures.

E. Techniques of defibrillation

Electric shock may be applied internally or externally only when ventricular fibrillation is confirmed by electrocardiogram or the thorax is opened and ventricular fibrillation is observed.[6,7]

1. External application.

Conductor lubricant and electrodes are applied at the suprasternal notch and 2-3 cm below the left nipple.

a. AC defibrillation. AC shocks of 60 cycles per second of 440 volts are applied for 0.25 second, resulting in a current of 5 amperes across the chest and 1.5-2 amperes through the heart. (Zoll's technique.) In patients over 200 pounds, 750 volts should be used. In children, 250 volts.

b. DC defibrillation. A single DC shock of 80 to 400 watt seconds for 2.5-3.0 milliseconds duration is applied across the chest. (Monophasic capacitor defibrillator.)

2. Internal application.

Padded sterile saline-soaked electrodes are placed directly on opposite surfaces of the heart within the pericardial sac following anterior incision through the fourth intercostal interspace.

a. AC defibrillation. Alternating-current shocks of 60 cycles per second of 110-220 volts are applied for 0.1 second, resulting in the flow of 1.5-2.0 amperes of current through the heart.

b. DC defibrillation. A single direct current shock of 10 to 40 watt-seconds is applied across the heart for 3-6 milliseconds. (Monophasic capacitor defibrillator.)

Conductive lubricant and firm contact of the electrodes upon the skin or pericardium is essential. Failure to achieve sustained defibrillation is an indication that the myocardium is anoxic and atonic, or the pH is low (acidosis) or the heart is hypothermic. Correction of these states is essential for successful difibrillation.

Atonia and anoxia produce a sluggish electrical pattern of fibrillation with spikes showing low amplitude and slow potentials. Following oxygenation and the injection of epinephrine, the ECG pattern is converted to a pattern of rapid potentials indicating increased irritability and tonus. Excessive irritability, causing repeated reversion to fibrillation following countershocks, is an indication for intravenous procainamide or quinidine in doses sufficient to depress irritability of the heart.

F. Post-resuscitation therapy (long term resuscitation)

Once the heart has been restored following a cardiac arrest, further therapy depends on the degree of hypoxic damage to the central nervous system and the cardiovascular system. If arrest was acute and resuscitation prompt, the patient may not manifest any sign or symptom of the accident and no further treatment is required. It is imperative that the damage be evaluated as soon as possible after resuscitation and that the proper steps be taken.

If respiratory function does not return or is not adequate, this must be provided for by a form of mechanical ventilation. Several different types of mechanical ventilators are available; they should be used by physicians familiar with this equipment. These devices vary in design, i.e., pressure-cycled or time-cycled, preset inspiratory pressure or volume, cycling frequency and inspiratory flow rate. The patient's ventilation is usually adjusted to produce hypocapnia and abolish respiratory effort.

If the patient is unconscious or artificial airway is required for a longer period of time, a tracheostomy should be considered to make adequate tracheobronchial toilet possible, and reduce dead space.

Since a major effect of the hypoxic insult will be manifested in severe brain edema, steps must be taken to lessen this effect as soon as possible after resuscitation.

To diminish brain edema, intravenous urea (40 gm in 5 per cent D/W) should be administered twice a day. Instead of urea, mannitol or THAM could be used. Corticosteroids are given intravenously 10-15 mg/kg daily for two to three days.

Hypothermia is generally recommended in such cases to prevent further damage to the brain during the postresuscitation period of cerebral edema. Patients[8] are cooled to temperatures of 30-33°C, for days if necessary, and chlorpromazine is administered (5-25 mg intramuscularly) to prevent shivering. Other drugs, i.e., vasopressors, alkalinizing drugs, digitalis and antibiotics are used frequently in this period.

The rest of the therapy is directed at the gener support of the patient. Maintenance of electroly balance, balance of fluid intake and output, an excellent nursing care are a few of the importa items.

G. Summary of steps in heart-lung resuscitation

1. The patient must be adequate for resuscitatio
2. Rapid diagnosis of arrest.
3. Ventilation must be re-established in less tha four minutes.
4. Start mouth to mouth (or nose) artificial re piration (12 times per minute).
5. With patient on a solid surface, apply extern cardiac massage 60 times per minute.
6. Observe for effectiveness of massage by pulsa tions, constriction of pupils and spontaneous respira tions.
7. Inject 2 ml of 1:10,000 epinephrine in heart i no spontaneous activity at three minutes.
8. Check for type of cardiac arrest (asystole o ventricular fibrillation) by ECG.
9. Apply external defibrillator if indicated by presence of ventricular fibrillation.
10. Give 10 ml 10 per cent calcium chloride intracardially.
11. Reverse acidosis with 44.6 mEq sodium bicarbonate if arrest persists over five minutes.
12. Continue external massage and artificial ventilation until spontaneous blood pressure and ventilation adequate to maintain the patient occur.
13. Perform venous cut down or start intravenou infusion of fluids.
14. Give continuous vasopressors to sustain blooc pressure if necessary.
15. Apply postresuscitation therapy as indicated
16. With return of vital signs the resuscitation procedures may stop at any step.

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The diagnostic accuracy in dissecting aortic aneurysms can be espectable even with the minimum of diagnostic tools but only vhen the lesion is constantly suspected. Unfortunately in the verage hospital the therapy is not very successful and it may be hat medical treatment will supplant surgery in the acute or activey dissecting patient.

ORIGINAL SCIENTIFIC ARTICLE

xperience with Dissecting Aortic Aneurysm In a Small General Hospital

3y B. Doshi, M.D.
. C. Alexander, M.D., F.A.C.P.
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The diagnosis of dissecting aortic aneurysm has lways been a medical challenge. Prior to the last ecade, this challenge has been of purely academic nterest, but the recent advances in reconstructive ascular surgery have made the diagnosis mandatory.[1] he cases in this report indicate that our diagnostic cumen has improved, even with the limited diagostic tools available in a small general hospital.

The incidence of dissecting aortic aneurysm will ary with the reporting institution and the type of atients treated in these institutions. Sheenan[2] reorted an incidence of 1:174, while Holland and ayley[3] found the average to be 1:381.

During the period of January 1, 1954, through ecember 31, 1963, at St. Joseph Mercy Hospital in etroit, Michigan, there were 18,832 patient admisions with 2,328 deaths and 1,004 autopsies. There ere seven diagnoses of dissecting aortic aneurysm stablished during this period, making an incidence n our own institution of 1:200 cases. Six were conirmed or made at autopsy while one was confirmed y surgical intervention.

Case 1

R.T., a 59-year-old white male, admitted to the ospital on 8/18/54 at 10:45 p.m., with the chief omplaint of epigastric pain. He was well until 1:00 .m. on the day of admission at which time he exerienced sudden, sharp, aching pain in the intercapular area, radiating around to the epigastrium. he pain subsided 30 minutes later while he sat uietly in a chair. There were no previous episodes, nd the pain was not associated with dyspnea, fever, hills, nausea, vomiting, nor was it aggravated by respiration. The pain recurred in the evening and resulted in his hospitalization.

The physical examination was not remarkable, excluding the blood pressure, which was 190-206/130-140. The impression was that the patient had hypertensive cardiovascular disease with a myocardial infarction. The studies were as follows: EKG was within normal limits; x-rays of the chest showed bilateral pleurisy and arteriosclerosis of the aorta; blood chemistries, CBC, and urinalysis were not remarkable. During the hospital course of about 24 days, he had low-grade fever, his hypertension persisted, and on two occasions he had recurrence of his chest pain. He also experienced an episode of transient cerebro-vascular insufficiency with resultant syncope.

While being evaluated for hypertension, he suddenly expired on 9/12/54. The autopsy showed a dissecting aneurysm of the aorta from the transverse portion to the renal arteries, left hemothorax, and cerebral malacia.

This patient obviously entered the hospital with a dissecting aneurysm, but the diagnosis was not suspected prior to death; although certainly on review, the diagnosis should have been strongly suspected.

Case 2

S.L., a 69-year-old white female, hospitalized on 3/29/57 with a chief complaint of severe anterior chest pain. She had had slight chest pain, cough, chills, fever, and dyspnea without orthopnea of about one week's duration. Chest pain became much more severe on the day of admission. Physical examination revealed a well-developed, well-nourished, acute and chronically ill female with a temperature of 100°. Heart showed left ventricular hypertrophy and there was a systolic murmur at the apex. Lungs revealed rales at both bases, with dullness and diminished breath sounds at the left base.

The impression was that of arteriosclerotic heart disease with myocardial infarction and possible bronchopneumonia. After hospitalization she continued to have chest pain and dyspnea in spite of narcotics, oxygen, and antibiotics. Temperature rose to 100.8° and she expired six and one-half hours after admission. No laboratory or x-ray studies were done.

Autopsy showed a dissecting aneurysm of the ascending aorta, measuring 25 x 20 x 15 cms, with rupture into both the pericardium and right pleural cavity. The aneurysm extended to the arch of the aorta in a "double-barreled" fashion.

Unfortunately, this is an example of a frequent occurrence in a dissecting aneurysm of the aorta. The patient is admitted to the hospital at a time when ancillary services are not readily available. Certainly the diagnosis probably could have been established by obtaining a routine chest x-ray when the patient was on the way from the emergency room to her room. It also illustrates two other points: (1) The rare finding of healed aneurysm of "double-barreled" configuration which occurs in approximately 9 per cent of cases. (2) Because of the grave condition on admission, adequate or complete histories are frequently not obtainable.

Case 3

H.D., a 71-year-old male, admitted to the hospital on 3/17/59 at 2:20 a.m. because of hematemesis associated with back pain. He was relatively well until the day prior to admission when he started getting severe, sudden, sharp pain in the interscapular area, associated with nausea and vomiting, but no hematemesis. On the morning of admission, he again became nauseated and restless, and vomited copious amounts of bright red blood and clots. At no time did the patient lose consciousness.

In the past he was known to have had pulmonary emphysema, generalized arteriosclerosis, hypertensive cardiovascular renal disease, and mild diabetes mellitus. Physical examination revealed a temperature of 102°; pulse, 120/min and regular; respiration, 28/min; and blood pressure, 180/100. The skin was dry and the patient appeared dehydrated. The lungs revealed pulmonary emphysema; the heart was not remarkable to physical examination. The abdomen was soft with no palpable masses; there was no CVA tenderness. The impression was that of upper gastrointestinal bleeding due to gastric ulcer and/or carcinoma. The possibility of dissecting aneurysm was the next consideration. He was stabilized with the usual treatment for upper gastrointestinal bleeding.

During the hospital course he had dyspnea intermittently and was thought to have pulmonary emboli. Pericardial friction rub was noted for two days. Later, abdominal discomfort and distention occurred. Vomiting continued and the patient became progressively dyspneic and cyanotic. An abdominal mass d veloped which was thought to represent dissectir aneurysm, but his general status prevented transfe much less surgical intervention. He subsequently e pired on 4/17/59, 30 days after hospitalizatio Studies included EKG, x-ray of the chest and gastr intestinal tract and were not remarkable. Autop revealed extensive hemorrhagic dissecting aort aneurysm beginning at the great vessels of the arc and extending down to the iliac vessels.

While the diagnosis of dissecting aneurysm of tl aorta was considered early in this patient and was fe to be definitely established later in the course of th patient's hospital stay, medical opinion was that th patient's condition would not warrant radical surg ical intervention, and so the correct diagnosis becam merely an academic triumph.

Case 4

C.H., a 75-year-old white male, admitted o 1/16/60 at 5:15 p.m. with sharp left lower quadrar abdominal pain followed by nausea and vomiting c 24 hours' duration. He had had two dark diarrhe stools on the morning of admission. The initial im pression was mesenteric thrombosis and possible ru tured diverticulitis. After hospitalization, he suddenl had three convulsive seizures, followed by droopin of the left corner of the mouth; vital signs cease and he was pronounced dead one hour and 1 minutes after admission. Autopsy showed fusiforn dissecting aneurysm of the abdominal aorta extendin from renal to common iliac arteries and perforatin retroperitoneally to form a hemorrhagic mass o 20 x 12 x 11 cm lying to the left of the mid-line.

The examiner here was presented with a gravely ill patient and there was no time to permit detaile history, adequate examination, or even the barest c laboratory and x-ray studies.

Case 5

H.R., a 54-year-old obese female, was admitted t the hospital on 3/23/61 at 4:20 p.m. because of sud den onset of severe substernal chest pain. She wa known to have had hypertension for many years an had been hospitalized 13 times in the past six year for arteriosclerotic heart disease.

In the past, the patient complained of intermitten

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edal edema, orthopnea, dyspnea on exertion, cough, aroxysmal nocturnal dyspnea, and palpitations. She stated that the present pain started suddenly in the left chest, was squeezing in character, and radiated to the left upper extremity and to the left side of the neck and face and to the back. The pain was constant, unrelieved by bed rest and medication. The atient stated that the pain was associated with lyspnea, and the dyspnea was aggravated by the lightest exertion.

Physical examination revealed an obese female apearing pale, cold, clammy, and in respiratory distress with a blood pressure of 160/90. Lungs revealed rales n both bases and there was a Grade III systolic murmur at the base transmitted to the carotid arteries and a Grade III diastolic murmur at the base. There was 1+ pitting edema of the legs.

The impression was that of chronic rheumatic valvular heart disease and hypertensive arteriosclerotic heart disease. She was treated with sedatives and narcotics. The previously instituted anticoagulant herapy was continued. The patient continued to have nausea, vomiting and pain. Vital signs were not emarkable until 24 hours after admission when she uddenly expired. Autopsy revealed dissecting aneurysm of the aorta beginning from the root of the aorta and extending to a point 2 cm proximal to the enal arteries with rupture into the pericardium.

This patient presented a difficult challenge to the examining physician in the emergency room in that he was known to have arteriosclerotic heart disease and was currently under anticoagulant therapy; while he did have an aortic diastolic murmur, there was also a positive history for rheumatic fever. A stable EKG pattern was one clue to the fact that this episode of extreme chest pain was not due to further myocardial damage caused by arteriosclerotic heart disease. A knowledge of the previous ausculatory heart findings would have been of immeasurable aid n the proper interpretation of this murmur.

Case 6

W.C., a 69-year-old white male, was first seen in he emergency room on 5/10/62 because of severe ubsternal chest pain. The pain began about one hour previously and caused him to fall with momenary syncope. He was known hypertensive for six ears and had had associated ankle edema and angina pectoris. Physical examination revealed an apprehenive, muscular male who appeared both pale and cyanotic; pulse, 76/min; respiration, 26/min; blood pressure, 200/110; and temperature, 98°. Examinaion of the heart, lungs and abdomen was not remarkable. The impression was that he had an acute myocardial infarction. The patient was given supportive care, including large doses of narcotics. The EKG showed ischemia.

On 5/11/62 he developed left pleuritic chest pain without associated friction rub. X-rays taken on 5/15/62 showed definite widening of the aorta compared to the previous films. Repeat EKG showed a normal pattern. A diagnostic left thoracentesis was done on 5/16/62, with recovery of 150 cc of bloody fluid. At this time, the diagnosis of dissecting aneurysm of the thoracic aorta was made and the patient was transferred to another hospital for surgery on the same day.

At surgery, he was found to have a dissecting aneurysm of the thoracic aorta which was divided, and appropriate surgery was done. His postoperative course was uneventful. He was discharged from the hospital on 5/26/62; unfortunately, he suddenly collapsed and died early in the morning on 6/7/62. No autopsy was obtained.

It was hoped that when the diagnosis was made and the patient apparently responded to surgery that we had, at last, salvaged a patient with dissecting aneurysm; this hope was short-lived.

Case 7

S.G., this 45-year-old white male admitted to the hospital on 1/8/63 with substernal chest pain and shortness of breath. The pain was associated with profuse perspiration, cold, clammy skin, nausea and vomiting. It was not relieved by home remedies. There was a questionable history of post-bulbular duodenal ulcer ten years previously. He had had some epigastric pain in August of 1962.

Physical examination revealed a pale, chalky, cyanotic male in severe distress. Blood pressure was 90/70. Heart revealed Grade III systolic murmur throughout the precordium; no diastolic murmur heard; no definite cardiomegaly present. The impression was that the patient had arteriosclerotic heart disease with myocardial infarction. Blood pressure rose to 150/102, with the administration of aramine, and an aramine drip had to be continued to maintain blood pressure. On 1/9/63, there appeared to be slight improvement and the pain was less severe. Blood pressure stabilized at 122/68.

At this time, an aortic diastolic murmur was first heard. It was at this time that the patient was thought probably to have a dissecting aneurysm. His condition remained unchanged and he was transferred the next day for possible surgery. X-rays taken on 1/10/63 showed some definite increase and widening of the thoracic aorta. Three serial EKG's had shown a development of subepicardial myocardial injury, but no pattern of infarction. The patient expired about 11 hours after transfer. The autopsy revealed acute dissecting aneurysm of the aorta extending from the aortic valve to the bifurcation of the left common iliac artery with rupture through the adventitia and massive acute hemopericardium.

The correct diagnosis was arrived at in this patient at least 36 hours before death. The fact that dissection extended from the heart to involve at least the renal arteries inferiorly was surmised from the fact that the patient, while in the hospital, developed a murmur of the aortic insufficiency plus abnormal urinary sediment findings which had not been present on physical evaluation carried out six months before terminal hospitalization. While surgery would necessarily be extensive in this patient, it offered his only chance.

Pathology

The majority of authors[4] believe that dissecting aneurysm of the aorta is due to medial necrosis of Erdheim. In the younger age group the degenerative process affects primarily the elastic lamina of the media. By contrast, in persons over 40 years of age, the degenerative process is of muscle, most often alone, but frequently associated with lesions of the elastica. Most large series attest to the pathologic association of arteriosclerosis and the clinical association of hypertension, especially in the older group, while in the younger group Marfan's syndrome and pregnancy are associated states. Numerous co-existing lesions have been reported and previously proposed as causes, i.e., trauma, coarctation of the aorta, infection, ergotamine, granulomatous giant cell aortitis, arteriosclerosis of the renal arteries without involvement of the aorta, tuberculous aortitis, and recently, carotid angiography.

While the majority of untreated patients succumb to this lesion, some do survive because of spontaneous re-entry in the formation of "double-barreled" aorta. Rarely complete healing with obliteration of the false sac may occur.

Clinical Manifestations

Chest, back, or abdominal pain is characteristically present, and, indeed, dissecting aneurysm of the aorta may present itself as an acute surgical abdomen or as sudden occlusive vascular phenomenon in the extremities. The pain is usually sudden in onset and frequently described as a tearing sensation, and while the patient usually presents with the severe pain, cases have been described where pain was absent, not recorded, or was minimal. Shock may soon follow in the course of the illness, and while the clinical state of shock is apparent, the blood pressure may not only be normal, but even at hypertensive levels. Acute myocardial infarction is the most frequently simulated condition and while there may be associated electrocardiographic changes, the pattern of infarction is absent. Subepicardial myocardial injury pattern may be associated with rupture into the pericardial cavity. (See Figure 1).

Aortic diastolic murmurs are described in 10 to 50 per cent of the various series, and the development of an aortic diastolic murmur in a patient suspected of having this lesion is naturally of great help in the diagnosis. Two instances were recorded in this series. In Case 5, the murmur was present on admission physical evaluation, whereas in Case 7, it developed during hospitalization. The finding of unequal pulses has been stressed, but a review of literature would indicate this finding to be the exception and not the rule.

Certainly the development of a cardiovascular emergency in a patient with coarctation of the aorta, pregnancy, or Marfan's syndrome, should suggest the possibility of this diagnosis. Neurological manifestations have been stressed in numerous articles[5] and, indeed, they were prominent in the present series. The multiplicity of findings are well discussed in numerous "Cabot cases."

A slight rise in temperature is usually seen if the dissection is extensive. Laboratory studies show nonspecific changes; leukocytosis is frequently present and anemia may develop with a large dissection, or if a nonfatal external rupture occurs. Abnormal urinary findings would indicate involvement of the renal arteries, that is, if the abnormalities were not previously present.

Radiographic Findings

The x-ray findings have for a long time been of great aid in the confirmation of the clinical diagnosis of dissecting aortic aneurysm. The first recorded case was published in 1913.[6] The most reliable finding is a sudden widening of the aortic shadow demonstrated by films taken within a short interval. This point is illustrated by Figure 2. The additional findings are usually due to some complication, that is, pleural effusion due to external rupture into the left pleural cavity and increase in the size of the cardiac silhouette due to rupture into the pericardium.

Most of the recent literature[7] on the radiological features of dissecting aneurysm of the aorta, deal with the changes seen on angiocardiography. The films taken with direct or retrograde aortography are much clearer than those obtained with venous angiography, but the risks involved with the former are also much greater. With angiography, the changes are much more definite: While the false lumen may not usually be demonstrated, the widening of the aortic wall beyond the normal 2 to 3 mm, to that approaching 1 cm, is demonstrated. The closer the aortic wall width is to 1 cm, the more certain is the diagnosis of dissecting aortic aneurysm. Especially will these procedures be valuable if one suspects imminent rupture and uses the techniques to confirm decisively the diagnosis. Here the risk of the procedure is negligible when compared to that of a "missed diagnosis."[8]

Diagnostic Accuracy

The diagnostic accuracy has improved remarkably

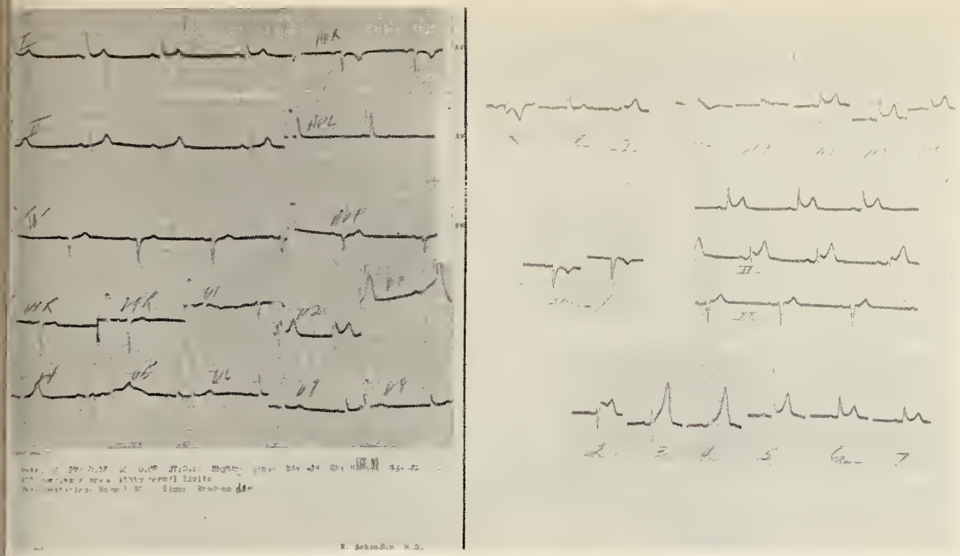

Figure 1. Normal pattern at left. Pattern at right shows subepicar-ial myocardial injury.

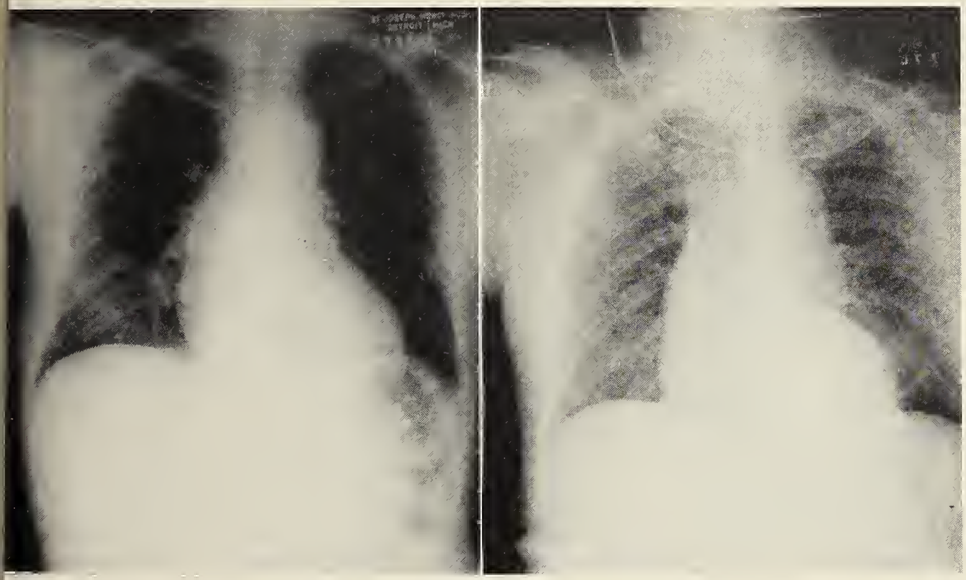

Fig 2. Sudden increase of aortic shadow.

during the past century, probably owing as much to the awareness of the lesion as to the improved techniques in the study of patients. That there should be difficulty in diagnosis is evident from the fact that the condition has been mistaken for myocardial infarction, embolism of the iliac artery, thrombosis of the femoral artery, acute surgical abdomen, kidney tumor, nephrolithiasis, pulmonary or mediastinal tumor, pancreatic or mesenteric cysts, subdiaphragmatic abscess, embolism of the brachial artery, perimediastinal effusion, etc. In 1922 the antemortem establishment of the diagnosis was sufficient reason to publish the fact in the British Medical Journal.

In reviewing the literature in 1929, Gager,[9] found 382 cases, with antemortem diagnosis made apparently in five instances. In 1936, Osgood et al.[10] reported on 1,400 cases, with only 11 cases correctly diagnosed —a correct diagnostic percentage of less than 1 per cent. Through the next 10 or 11 years, published articles indicated that the diagnostic accuracy was still not too outstanding. In 1947, David[11] reviewed 17 autopsy cases from Massachusetts General Hospital during the period 1937 to 1946 and noted eight were correctly diagnosed antemortem.

Subsequently, other authors recorded high percentages of correct diagnosis, although inspection of the articles indicated that they felt that the diagnosis was made if it was considered in the differential diagnosis. In 1960, Erb and Tullis[12] noted that the average incidence of antemortem diagnosis was 30 to 50 per cent; in their review of the literature and in their own series from John Gaston Hospital for the preceding ten years, they had a 27 per cent correct antemortem diagnosis.

Prognosis

The prognosis in untreated dissecting aneurysm of the aorta is extremely poor. There are isolated cases of long-term survival. Allen et al.[13] states that 20 per cent of the patients die within 24 hours, and only 20 per cent survive as long as two weeks. In contrast to this, Kuipers and Schatz[14] have presented a more optimistic outlook. In a summary of 26 cases, 11 survived beyond six weeks without surgical therapy, but seven of these were dead at the time of publication of the article, with an average survival time of 28 months (range, 2 to 57 months). The four survivors had lived 8, 10, 16, and 48 months.

Treatment

When the patient is first seen, treatment is directed to counteracting shock and to the relief of pain and dyspnea, but the definitive treatment is surgical. Gurin et al.[16] are usually credited with the first rational surgical approach. Twenty years later, Shaw and Johns each reported similar surgical procedures, but all three patients died in the postoperative period. Following this were several reports of successful surgery.

The procedure of fenestration, first perfected by DeBakey, was usually employed.[17] DeBakey, who has contributed most to the surgical treatment of all aortic aneurysms including dissecting aortic aneurysms, feels that the surgical correction of dissecting aortic aneurysms should be more radical to include excision of the diseased vessel and prosthetic replacement of same.[18] This approach is shared by many authors in this field.

A recent report on the use of antihypertensive agents may alter our initial therapy and would certainly warrant consideration where a major cardiovascular surgical team is not immediately available.[15]

Summary

A ten-year experience with dissecting aneurysm of the aorta in a small general hospital is recorded. While diagnostic accuracy has improved, the therapeutic results unfortunately remained unchanged. Seven cases were encountered over this ten-year period, and the antemortem diagnosis was made in three. In two of the three, the patients' general condition was determined to be unsatisfactory for surgery, whereas in the third, while apparent surgical success was accomplished, the patient expired thre weeks postoperatively.

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Merits Comment

The new Forum Page in Michigan Medicine has attracted national attention.

A recent issue of "Association Newsletter," a national publication for Association Managers, reported that "a Forum Page has been added to Michigan Medicine and members are invited to express their views on a selected question each month."

ORIGINAL
SCIENTIFIC
ARTICLE

The Role of Kidney Biopsy In Modern Medicine

By James A. Greene, Jr., M.D.
Leon Lapco, M.D.
John M. Weller, M.D.
All of Ann Arbor

In evaluating patients with renal disease, it is important to establish the correct diagnosis. Only then can the physician have a clearer idea of prognosis and provide intelligent management.

Useful information can be obtained from the history, physical examination, urinalysis, renal function tests, protein excretion rate, bacteriologic examination and pyelography, but even with these the diagnosis may not be clear.

During the past 15 years percutaneous renal biopsy has been used increasingly to establish the diagnosis. One of the earliest reports of needle biopsy of the kidney was by Ball in 1934.[1] Alwall in 1945 obtained tissue in 10 of 13 cases.[2] The technique was introduced into this country by Parrish and Howe[3] in 1953 and Kark and Muehrcke in 1954.[4] This procedure has been available at The University of Michigan Medical Center for the past ten years.[5,6]

The purpose of this paper is to review the results of 238 renal biopsies done between July 1959 and October 1965 and to illustrate how renal biopsy is used in the diagnosis of renal disease.

* * *

Percutaneous renal biopsy can be done with relative safety in properly selected patients. There are three absolute contraindications: (1) evidence of a hemorrhagic tendency, (2) lack of cooperation of the patient, and (3) the presence of a solitary kidney. The hypertrophied kidney in a patient with one hypoplastic kidney is likewise not biopsied. Renal biopsy usually is not helpful in terminal chronic renal disease, although it may be extremely useful in differentiating acute reversible renal failure from chronic nephritis. The right kidney preferentially is biopsied because of the proximity of the spleen and large vessels to the left kidney.

The technique of percutaneous renal biopsy has been described previously.[6] The patient should have a normal bleeding time, clotting time, prothrombin concentration and number of platelets on blood film. Renal function should be appraised, preferably with a creatinine clearance. Blood should be immediately available for transfusion.

Written permission must be obtained from the patient after the procedure has been carefully explained.

Intravenous pyelography is useful for localization of the kidneys; however, if function is impaired and the kidneys do not visualize, an x-ray of the abdomen is sufficient, if both renal shadows are seen. The patient is sedated with secobarbital and placed prone on a sandbag. The point at which the biopsy will be done is chosen from measurements taken from the x-rays. A 21 gauge spinal needle is used to determine the exact location and depth of the kidney. The biopsy is then taken with a Franklin modification of the Vim-Silverman needle. Care must be taken in the movement of this needle in order to avoid laceration of the kidney. Following biopsy, pressure is applied over the site for 30 minutes. The patient is kept in bed for 24 hours under observation for signs of bleeding.

Percutaneous renal biopsy was attempted 238 times at The University of Michigan Medical Center. Adequate tissue containing five or more glomeruli was obtained in 204, or 86 per cent (Table I). Significant complications occurred in 24 (10 per cent) of the 238 patients undergoing renal biopsy (Table II). Microscopic hematuria was a fairly constant finding during the first 24 hours after biopsy, but usually subsided promptly. Perirenal hematoma was a complication in five patients. These may be palpable as well as showing renal displacement on pyelography. One death due to delayed hemorrhage occurred. Although

TABLE I
Results of 238 Attempted Kidney Biopsies

	Number	Per Cent of Total
Total Biopsies Attempted	238	100
Number of Attempts Discontinued	12	5
Uncooperative Patient	10	4
Bleeding from Skin	2	1
Number of Biopsies Completed	226	95
Adequate Tissue Obtained	204	86
Inadequate Tissue Obtained	22	9
Number of Complications	24	10

The authors are all with the Department of Internal Medicine at the University of Michigan Medical School. Doctor Greene is an Assistant Professor; Doctor Lapco, a Research Fellow, and Doctor Weller, a Professor.

TABLE II
Complications Occurring in 226 Completed Biopsies

	Number
Gross Hematuria	9
Perirenal Hematoma (1 Death Due to Recurrent Bleeding)	5
Syncope During Biopsy	4
Ureteral Colic	2
Severe Pain at Biopsy Site	2
Bleeding from Trocar	1
Hypotension Without Bleeding	1
Total Number of Complications	24

it did not occur until six weeks later, it was felt to be directly due to the biopsy.

The treatment for hemorrhage is strict bed rest until 48 hours after subsidence of symptoms and signs. Transfusion is rarely required. Nephrectomy has been reported as being necessary to control bleeding.[7]

* * *

During the biopsy, pain was experienced in about 20 per cent as the needle was introduced into the kidney. Severe pain following biopsy, lasting from one to three days, was present in two patients. Four patients lost consciousness during the procedure and it was discontinued. In none of these was any complication noted after the patient was removed from the sandbag.

In 34 patients the biopsy was unsatisfactory; in 22 of these inadequate or no renal tissue was obtained. The procedure was discontinued prior to actual biopsy in 12 patients because the patient was not cooperative, was unable to tolerate the sandbag, or because of excessive bleeding from the skin incision. The high rate of success (86 per cent) probably is attributable to the fact that only a limited number of well-trained individuals have done the biopsies at this institution.

The following case reports illustrate the importance of renal biopsy in establishing the diagnosis.

Case 1

H.H., a 40-year-old male, was admitted for congestive heart failure. Two years prior to admission mild elevation of blood pressure was found; however no therapy was advised. One month prior to admission he had fever, chills, cough and sore throat. Three weeks later he noted progressive dyspnea on exertion, edema of the legs, fatigue and weakness. He gave no history of renal disease and stated that a urinalysis one year previously was normal. On physical examination he was in moderate respiratory distress. The blood pressure was 160/100 mm Hg. There was neck vein distention and rales were heard in both lungs. The heart was enlarged to 2 cm to the left of the mid-clavicular line and the liver edge was palpable 3 cm below the right costal margin. There was 4+ ankle edema.

The urine showed specific gravity 1.020, pH 5.5, 4+ albumin, trace of sugar, 10 to 20 RBC and 50 to 100 WBC per high power field, and many granular casts per low power field. The Hgb was 12.8 gm/100 ml and WBC 7,400/cu mm. BUN was 53 mg/100 ml, serum creatinine 2.3 mg/100 ml with a creatinine clearance of 70 liters/24 hours. The total serum protein was 5.5 gm/100 ml with 31 per cent albumin and 5 per cent alpha-1, 18 per cent alpha-2, 18 per cent beta and 28 per cent gamma globulins. FBS was 85 mg/100 ml, and a 24-hour urine protein was 14.6 gm. The antistreptolysin titers were 833, 2,500 and 1,250 Todd units. C-reactive protein was 6+. Intravenous pyelograms showed poor visualization.

The interpretation of the renal biopsy was acute and early subacute exudative and proliferative glomerular nephritis. Three years following admission, this patient showed no abnormality in renal function or urinalysis and had a normal blood pressure.

Case 2

C.G., a 37-year-old female, was admitted for evaluation of hypertension. Six years prior to admission, during her fifth pregnancy, blood pressure and urinalysis were normal. One year prior to admission, during the third month of her sixth pregnancy, she was noted to have elevated blood pressure (170 mm Hg systolic), albuminuria and minimal ankle edema. Eight months prior to admission she delivered a premature 2½ pound infant. Her blood pressure returned to normal but ankle edema persisted.

Two months prior to admission she noted a raised nodule on the left anterior leg which was first yellow, then became red and painful. This pain lasted one week, then the nodule gradually resolved. On admission two months later she appeared well. Her blood pressure was 188/128 mm Hg and the optic fundi showed Grade II arteriosclerotic changes. There was a 5 cm slightly raised, indurated, irregular, erythematous, non-pigmented, non-tender nodule on the anterior aspect of the left leg. There was no edema.

The urinalysis showed specific gravity 1.013, pH 5.5, 4+ albumin and 0 sugar. There were 5 to 10 RBC and 3 to 5 WBC per high power field and occasional granular casts per low power field. The Hgb was 14.7 gm/100 ml, and WBC 8,200/cu mm. BUN was 14 mg/100 ml, serum creatinine 1.03 mg/100 ml, with a creatinine clearance of 145 liters/24 hours. The glucose tolerance test revealed a FBS of 73 mg/100 ml; one-half hour, 104; one hour, 150; one and one-half hours, 133; two hours, 118, and three hours, 93 mg/100 ml. The glucose tolerance test following cortisone administration was abnormal. Twenty-four hour urine showed 9.9 gm of protein. The total serum protein was 4.6 gm/100 ml with 43 r cent albumin and 4 per cent alpha-1, 18 per cent ɔha-2, 24 per cent beta and 11 per cent gamma ɔbulins. Intravenous pyelograms were normal. opsy of the lesion on the leg was interpreted as crobiosis lipoidica diabeticorum.

A renal biopsy was performed when the blood pres- re returned to normal. The interpretation was obable diffuse Kimmelstiel-Wilson disease.

Case 3

A.M., a 38-year-old female, was admitted for aluation of albuminuria. One year prior to admis- n albuminuria was found when she was treated for ricose veins. Eight months prior to admission she ted edema of the ankles, face and hands, associated th fatigue and nocturia. There was a family his- y of hypertension. On physical examination she peared well and her blood pressure was 150/100 n Hg. There were Grade II arteriosclerotic anges in the optic fundi and 2+ edema of the kles.

The urine specific gravity was 1.015, pH 6.0, 3+ umin, 0 sugar and 1 to 3 RBC and 3 to 6 WBC r high power field with 3 to 6 granular casts per v power field. Oval fat bodies were present. Hgb s 10.7 gm/100 ml and WBC 6,950/cu mm. The JN was 33 mg/100 ml, serum creatinine 0.92 /100 ml, with a creatinine clearance of 103 ers/24 hours. The total serum protein was 5.9 n/100 ml, with 60 per cent albumin and 6 per cent ha-1, 6 per cent alpha-2, 12 per cent beta and 16 r cent gamma globulins. Kahn serologic reaction s positive and the treponema pallidum immobiliza- n test was negative. LE preparations were negative. travenous pyelograms were normal.

The interpretation of the renal biopsy material was tive membranous and proliferative glomerular phritis. One year later the blood pressure was 0/80 mm. Hg on antihypertensive medications, the rum creatinine was 0.92 mg/100 ml, and she felt ll.

Case 4

J.G., a 16-year-old female, entered the hospital for aluation of edema. One month prior to admission e noted the insidious onset of ankle and facial lema. She had been treated with diuretics and lost eight pounds. Except for fatigue and headaches she was asymptomatic. There was a past history of frequent sore throats. Family history disclosed that her father died of systemic lupus erythematosus at age 33. On physical examination the blood pressure was 120/90 mm Hg and there was 2+ edema of the extremities.

The urine showed specific gravity 1.020, pH 5.5, 4+ albumin, 0 sugar, and 3 to 4 RBC and 10 to 15 WBC per high power field with many oval fat bodies. There were many hyaline, granular and fatty casts seen per low power field. The Hgb was 12.8 gm/100 ml, and WBC was 6,500/cu mm. The serum creatinine was 0.87 mg/100 ml, with a creatinine clearance of 82 liters/24 hours. FBS was 87 mg/100 ml, a two-hour post-prandial blood sugar 112 mg/100 ml, and total serum protein 4.8 gm/100 ml, with 34 per cent albumin and 6 per cent alpha-1, 22 per cent alpha-2, 18 per cent beta and 20 per cent gamma globulins. Twenty-four hour urine protein was 11 gm. LE cell preparations on many occasions were negative. An ASO titer was 12 Todd units. The C-reactive protein was negative. Intravenous pyelograms were normal.

Renal biopsy was done and 14 glomeruli were obtained on the specimen. There was a uniform diffuse thickening of the basement membranes of all glomeruli. The interpretation was membranous glomerular nephritis. Seven months following biopsy she developed hemolytic anemia with dyspnea, fatigue, frontal headaches and increased swelling of the ankles. Examination showed a blood pressure of 120/90 mm Hg, pulse 120/minute and 3+ edema of the ankles. Urinary findings were unchanged. Hgb was 4.3 gm/100 ml, WBC 8,300/cu mm, and serum creatinine 3.9 mg/100 ml. The serum creatinine rose to 8.1 mg/100 ml, at which time she was treated with 200 mg hydrocortisone daily. Her Hgb rose to 11 gm/100 ml, and the serum creatinine eventually fell to 2.93 mg/100 ml. Three years following this she was essentially asymptomatic on 10 mg prednisone daily and thiazide diuretics. Physical examination was normal and urinalysis showed specific gravity 1.015, pH 7.5, 2+ albumin, 0 sugar, 0 RBC and occasional WBC per high power field and occasional hyaline casts. The Hgb was 15.4 gm/100 ml, serum creatinine 0.88 mg/100 ml, with a creatinine clearance of 142 liters/24 hours. LE cell preparations continued to be negative. On re-evaluation of the

Kidney biopsy is valuable in establishing accurate diagnosis in atients with renal disease. Our experience with 238 renal biopsies one during the past six years is reported. Adequate tissue was btained in 86 per cent of attempted renal biopsies. Complications ccurred in 10 per cent. Kidney biopsy should only be done in elected patients, after the benefits are carefully weighed against he risks.

renal biopsy material the changes were felt to be suggestive of the diagnosis of lupus glomerulitis.

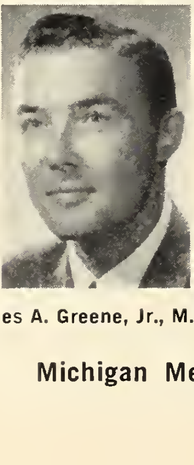
Case 5

G.B., a 30-year-old female, was admitted for evaluation of persistent microscopic hematuria. Twenty-two years prior to admission she had dysuria and was treated for kidney infection. Thirteen years prior to admission, microscopic hematuria was noted during her first pregnancy. This was persistent on every subsequent urinalysis. During her second and third pregnancies she developed ankle edema which cleared after delivery.

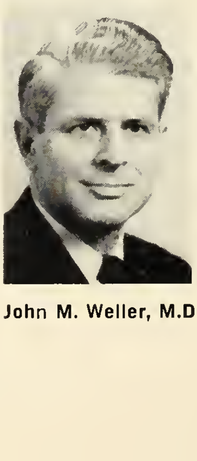
One year prior to admission, she had fever, gross hematuria and right flank pain and was treated for kidney infection. One month prior to admission she had another episode of right flank pain with radiation to the groin and dysuria. On admission she appeared well. Her blood pressure was 95/68 mm Hg. Costovertebral angle tenderness was present on the right. There was no ankle edema.

The urine showed specific gravity 1.022, pH 7.0, 1+ albumin and 0 sugar. The sediment was loaded with RBC and there were rare WBC per high power field. White blood cell, red blood cell and granular casts were noted. The Hgb was 12.3 gm/100 ml, and WBC 9,650/cu mm. The BUN was 11 mg/100 ml and the serum creatinine 0.83 mg/100 ml, with a creatinine clearance of 100 liters/24 hours. FBS was 81 mg/100 ml, and the total serum proteins 6.8 gm/100 ml, with 58 per cent albumin and 5 per cent alpha-1, 7 per cent alpha-2, 9 per cent beta and 21 per cent gamma globulins. Urine culture showed greater than 100,000 colonies of coagulase-negative staphylococci per ml urine and a 24-hour urine was negative for acid-fast bacilli. Intravenous pyelograms were normal. Cystoscopy showed minimal trigonitis.

The clinical impression was recurrent chronic pyelonephritis, although five of six urine cultures showed less than 1,000 colonies of bacteria per ml. Renal biopsy showed an interstitial infiltrate with periglomerular fibrosis and arteriolosclerosis. The interpretation was pyelonephritis and arterioloneph-rosclerosis.



James A. Greene, Jr., M.D.



John M. Weller, M.D.

TABLE III
Diagnoses made in 204 Adequate Biopsies

	Numb
Acute Proliferative Glomerular Nephritis	19
Subacute Glomerular Nephritis	10
Chronic Glomerular Nephritis	22
Membranous Glomerular Nephritis	47
Membranous and Proliferative Glomerular Nephritis	14
Focal Thrombotic Glomerular Nephritis	1
Proliferative Glomerulitis	12
Lupus Nephritis	13
Chronic Pyelonephritis	9
Interstitial Nephritis	2
Arteriolonephrosclerosis	26
Intercapillary Glomerulosclerosis—Diffuse	14
Intercapillary Glomerulosclerosis—Nodular	5
Acute Tubular Necrosis	1
Kaliopenic Nephropathy	1
Diffuse Granuloma	1
Cortical Scar	1
Cortical Adenoma	1
No Disease Evident	14

Discussion

Percutaneous renal biopsy is a valuable adjunct i the diagnosis of renal disease. Histologic examinatio of renal tissue may confirm, or on occasion may alte the clinical diagnosis with attendant therapeutic an prognostic implications. In the majority of patient where adequate tissue is obtained a specific diagnosi can be made (Table III).

Renal biopsy is most useful in evaluating diseas which diffusely involves the kidneys. It is less satisfactory in establishing the presence of pyelonephriti because of the patchy nature of this disease; howeve on occasion this diagnosis was confirmed. Cultures c biopsy specimens, even in clinically active pyelonephritis, are rarely positive, but may yield the same o ganism present in the urine.

Renal biopsy is very useful in establishing the exten of involvement as well as the diagnosis of the cause of the nephrotic syndrome as illustrated in the firs four cases. Entities causing the nephrotic syndrom range from acute to subacute to chronic glomerula nehpritis, idiopathic nephrotic syndrome, diabeti intercapillary glomerulosclerosis, lupus erythematosus amyloidosis and renal vein thrombosis. Renal biops is of definite prognostic, as well as therapeutic, valu in these patients in that the decision to use steroids i the treatment of the nephrotic syndrome is best base on the histologic findings.

The major complication of renal biopsy is hemorrhage. This usually becomes apparent within the firs hour after biopsy and is uncommon after four hour Bleeding may be brisk enough for hypotension an shock to occur. The treatment is symptomatic wit continued bed rest until symptoms subside. Occasionally transfusion is necessary. The one death i our series occurred in a patient having polycythemi which was not under control. In retrospect this patient should not have had a renal biopsy. Furthermore, prompt recognition of the delayed hemorrhag

(Continued on Page 277)

Significantly displaced fractures of the patella are usually oper- ed upon. Most orthopedic surgeons prefer patellectomy to open duction as a surer means to prevent traumatic arthritis. This se report reveals that degenerative arthritis is not the inevitable quel to open reduction of patellar fractures.

ORIGINAL
SCIENTIFIC
ARTICLE

Fracture of the Patella orty-Four Years Later . . .

y John O. Goodsell, M.D.
aginaw

The treatment of patellar fractures, other than un- splaced cracks, is an unsettled issue. Apparently no e advocates nonoperative treatment, but there animity of opinion ends.

Three operations, with minor variations, are avail- le; total excision, partial excision, and open reduc- on (called "suture" by many.) Nearly everybody ems to agree that repair of the lateral quadriceps pansions is crucial, giving credit to Lorenz Boehler 929)[1] or sometimes even to Joseph Lister (1877).[2]

* * *

The weight of published statistics, interpreted by eir collectors, appears to favor excision, either par- l or total. Most surgeons distinguish between com- inuted and transverse, relatively uncomminuted actures to select treatment; but most also express finite sentiment either for or against disposal of the tella. Some who agree essentially with Brooke[3] that is unimportant to save the sesamoid are D'Netto,[4] est,[5] Whittaker,[6] Dobbie and Ryerson,[7] Watson- nes,[8] and Duthie and Hutchinson.[9]

Strong sentiment for salvation of the patella is ex- essed by DePalma,[10] Hipps,[11] and Bruce and almsley.[12] Much of the argument against patellec- my is based on animal experimentation, especially e development of degenerative arthritis in rabbit ees after patellectomy.

Most authors accept the production of some de- nerative arthritis after patellectomy, but indicate at: (1) it is unlikely to be of functional signifi- nce; and (2) it is better in any event than the thritis which will result from an incongruous patella. he case to be reported suggests that patellar incon- uity will not inevitably lead to disabling arthritis.

The availability of this man's original service record permitted unusual accuracy of history.

Case Report

H.R., a 67-year-old man, was presented to the orthopedic consultant (the author) at the Saginaw Veterans Administration Hospital on June 25, 1963. He had come from the woods of Northern Michigan because his right knee seemed to bother him a little more than it had in the past. His main concern was not that the knee disabled him, but that it might.

The first part of this history has been confirmed by his Navy medical record. On 3/5/19, aboard the *U.S.S. El Oriente* he fell on the deck in rough weather and sustained a knee injury. Swelling and pain developed and persisted in the knee. In early April x-rays showed a transverse fracture of the patella, and on 4/11/19, an operation was done under local anesthesia. The record indicated that a small fragment was removed, and "the tendinous part sutured and ends approximated with chromic catgut." All immobilization was removed 6/23/19.

* * *

There was slow recovery of function. On 8/11/19 the fracture was felt to be healed, and he was returned to duty. However on 8/28/19 he was given a medical discharge from the service because of persistent swelling and limitation of motion of his knee. The range of motion was not described in

The Author
John O. Goodsell, M.D.

Doctor Goodsell, 1600 N. Michigan Avenue, Sagi- aw, is in private practice.

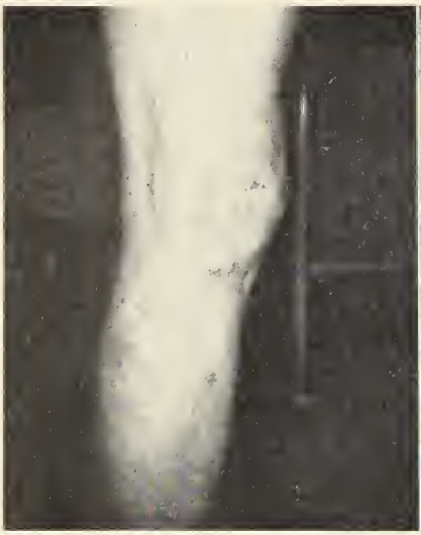


Figure 1. Right knee extension, standing, 6/25/63.

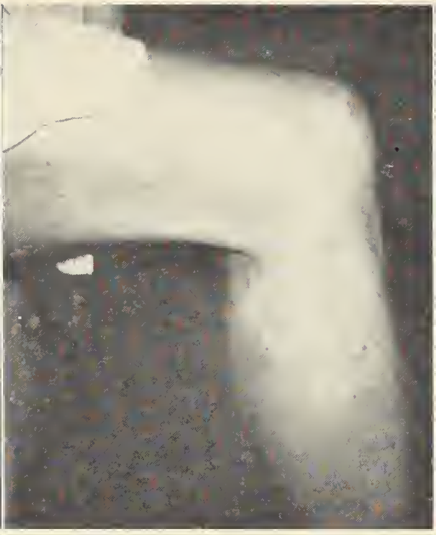


Figure 2. Right knee flexion, sitting, 6/25/63.

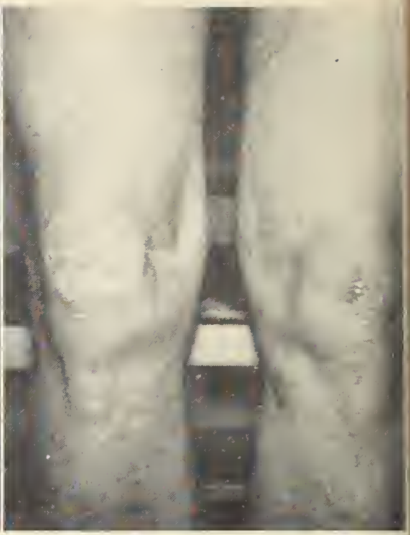


Figure 3. Frontal view, bo knees, 6/25/63. Note absen of peripatellar swelling.

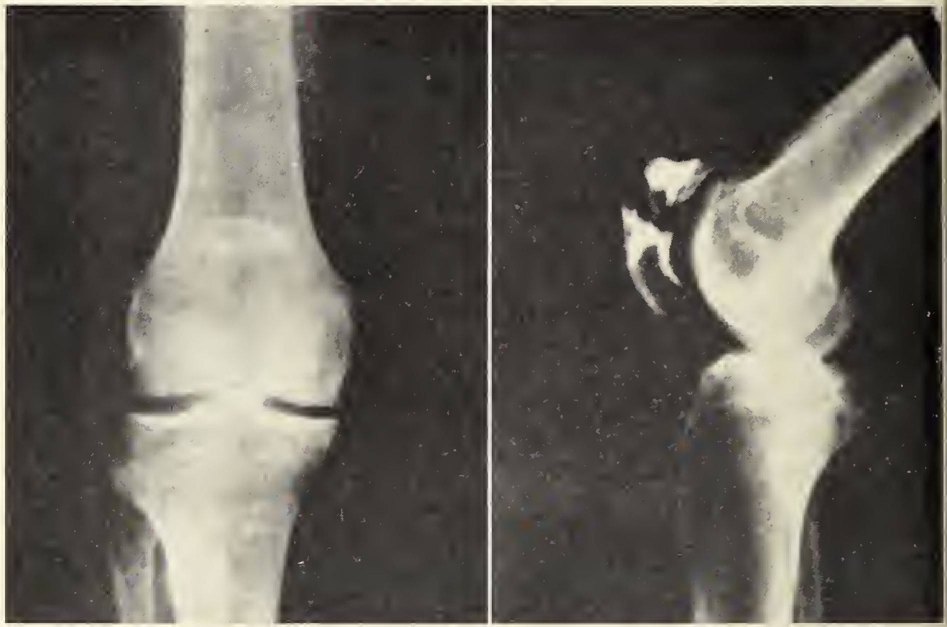


Figure 4. A.P. and Lateral X-ray, right knee, 6/24/63.

degrees at that time or at any other time in the record.

Not long after discharge from the service he believed he could do almost anything, and could run with no trouble. Over the years he did a great variety of jobs, including carpentry, plumbing, and electrical work. For three years, from 1927 through 1929, he worked in a large industrial plant, and quit this job "because of my lungs." Ever since that time his main occupation had been cutting and hauling timber in the northern woods.

Seven or eight years ago, while hauling timber through the snow covered woods, his legs bro through the crust and he fell, twisting his knee. Pri to that he had no trouble with the knee; since the he had occasional episodes of swelling and discon fort, but never to the extent that he was prevente from doing his work.

Examination on 6/25/63 revealed a vigorou elderly man who walked with no visible limp. H stood with no deformity of his lower extremities, an minimal asymmetry. There was a well healed, ve old transverse scar across the right knee anterior The right quadriceps muscle looked slightly atroph and measured three-fourths inch smaller than the left.

Knee extension on the right in the standing position was estimated at 180 degrees, and flexion on an attempt to squat estimated at 100 degrees. There was minimal crepitation. There was no increased heat, no palpable swelling, and no other deformity visible. (Figures 1, 2 and 3)

Anteroposterior and lateral x-ray examination of this knee 6/24/63 (Figure 4) revealed an ununited fracture, more or less transverse, with slight separation of fragments, at about the junction of the middle and upper one-thirds of the patella.

There was only the slightest evidence of degenerative arthritis in these x-rays. The joint space between the femur and patella as well as between the tibia and femur looked little narrowed, if any. There was practically no spurring except very slightly on the upper, anterior femoral condyle margin.

* * *

Because this knee had served him well for 44 years since the injury, H.R. was reassured that the history, physical and x-ray findings suggested that the knee should serve him well the remainder of his days.

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See index to advertisers on page 327.

KIDNEY BIOPSY

(Continued from Page 274)

probably would have led to successful treatment.

Careful selection of patients, as well as close follow-up in the immediate post-biopsy period, should reduce serious complications to a minimum. It is a technique, however, that should be performed only by those who have been adequately trained in its use and who are fully aware of its complications. Renal biopsy should not be done unless the indications for it are clear and no contraindications exist.

Summary

Percutaneous renal biopsy is an accepted procedure which is an extremely valuable adjunct in the diagnosis of patients with renal disease. It should be carried out only by trained individuals. Adequate tissue for diagnosis has been obtained from 86 per cent of our patients. Significant complications occurred in 10 per cent of these 238 renal biopsies. These complications nearly always may be handled successfully by conservative management. Before it is performed, the benefits of biopsy should be weighed against its risks.

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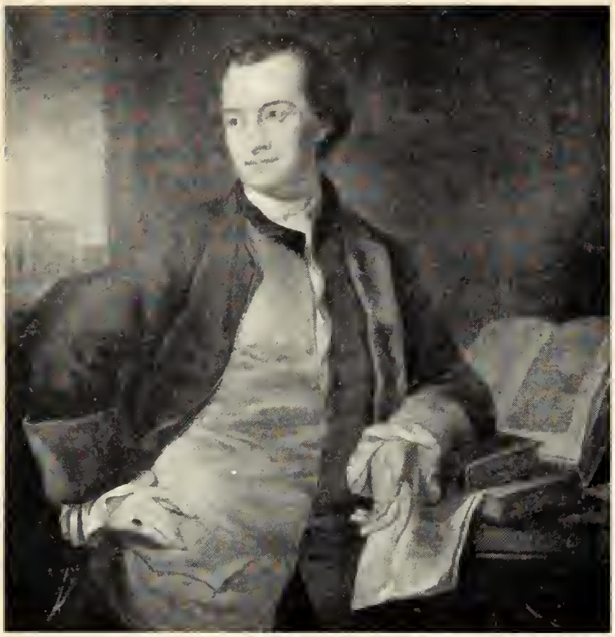
"Michigan Medicine" depends upon those in the know to keep their colleagues informed on their special, perhaps unique, knowledge of clinical matters.

Even if you are not sure that your experiences and findings are of real interest to the majority of readers, we invite you to submit them for review.

In the case of our Journal, we consider our readers the most important contributors, and we shall continue to invite and accept the best scientific papers possible.



John Morgan, M.D. This portrait was done by Angelica Kauffman. The photo was provided for use in Michigan Medicine by the University of Pennsylvania Medical College.

John Morgan, M.D. Philadelphia, 1765

By C. Howard Ross, M.D.
Ann Arbor

Hermann Boerhaave, M.D., of the Medical Faculty, University of Leyden, The Netherlands, was the bubbling father of modern medical teaching, absorbing in eclectic fashion the best of medical knowledge in his day. He dished it out generously without confining notes to the eager and the willing.

He became host to Peter the Great of Russia in 1715. Peter knew not a word of Dutch. Sitting with the inspired students one day, he drank in the great master and deeply felt the urge to surge, with unfolding and determined plans for Russian Medical Education.

Boerhaave stimulated his students to such a high contagious pitch that they became medical missionaries over this wide world.

A Chinese Mandarin wrote him a letter, addressed to "Dr. Boerhaave, Europe," and it was duly delivered.

John Munro, one of his most attentive students, helped found the Medical School at Edinburgh, Scotland. There were three generations with the surname Munro, covering 126 years of Anatomy. The Medical Teachers, Munro and Cullen, awaited the day of John Morgan, whose life span extended from 1735 to 1789.

* * *

John Morgan was a Philadelphia blue-blood, receiving a Bachelor's Degree in the first Class of 1757, College of Philadelphia.

As a youth he read Culpepper's "The English Physician," the first true medical work published in America, 1708. After medical apprenticeship, Morgan became a war surgeon in the French and Indian struggle.

He later sailed to England. There he met the Hunter brothers. He journeyed on to Edinburgh; plunged onto the new work, receiving his medical degree with the class of 1763.

The field of Medical Communications touched him deeply, when he perused faithfully Morgagni's books on "The Seats and Causes of Disease" and Auenbrugger's treatise on "Percussion."

A few years of travel followed, including Padua on his itinerary. He actually interviewed his hero Morgagni and in his thirst for educational adventure, he met such literary notables as Voltaire.

With great ambition, dedication and dynamism he returned to Philadelphia.

After much sparkling paper work in advance, he established the first Medical School in Anglo-Saxon America, May 13, 1765. Morgan assigned himself a further classification which may be now described as "Internist."

* * *

As Medical Communicator, he manipulated his colorful inaugural address over two full days, giving it the title, "Discourse upon the Institution of Medical Schools in America." Here was the Medical Magna Carta. He proclaimed that training should involve both medical theory and "walking the wards." Philadelphia's "College of Physick" was thus born and later became a part of the University of Pennsylvania.

Note well the man, the place, the date.

Whether we like it or not, the University of Pennsylvania sired us all.

Morgan was quicker on the trigger than Samuel Bard, who performed the same service for New York in 1768, but a little sluggish, when compared with Mexico, where the University founded the first New World Chair of Medicine in 1580. The interval be-

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Doctor Ross, 715 N. University Avenue, Ann Arbor, is in private practice. As president of the Michigan Chapter of the American Medical Writers Association he gave this paper at the 1965 AMWA national convention.

ween Mexico and Morgan is compared to the span between Yorktown and today's Detroit.

George Washington's host, William Shippen, Jr., was elected Professor of Anatomy and Surgery. Later the number three man was none other than Benjamin Rush, who held the Chair of Chemistry in 1769. He advanced on to the broader fields of Medicine and created a border-line approach to Psychiatry. He served at one time with our Revolutionary Army. Rush was a delegate to the Continental Congress and signed his name to the Declaration of Independence.

We are rushing our history a bit too fast. Returning to the day when Johnathan and John Bull could no longer agree, Morgan was elevated to the high office of "Director General of the American Medical Services." This technically made him the Arch Enemy of John Hunter, Surgeon General to the Armed Forces of George III. However, the two boys never considered themselves as medical opponents.

* * *

Morgan's rapid rise to fame did not condition him to manipulate counter-forces. Unhappiness gradually settled down when communications failed. John suffered from increasing annoyances and believed that Shippen was his snake-in-the-grass. In the big inquiry of 1777, Congress at first dismissed Morgan, then later exonerated him. John then spent his venom upon Shippen, turning his tongue into a pizzle-whip. He refused to be contaminated as a faculty mate with such a man and withdrew from his medical teaching assignments altogether.

The Medical Professorship was held open as a compromise bait but there was no ready solution to this personality hornets' nest. It was a case of unraveling well-woven yarn, pull and tug, clash following clash.

In Morgan's day, our first Pharmacopoeia was published by William Brown in 1778, seventy-four years prior to the founding of the American Pharmaceutical Association.

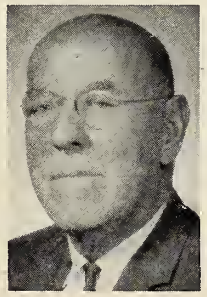
Time rushed on with tearing and depleting force. The crescendo was long since spent. The diminuendo dragged painfully. It was not a story of living happily ever after.

Years later old Dr. Benjamin Rush made a horse-and-buggy call to the bedside of John Morgan. The beast was tied in front of a filthy hovel. Inside, surrounded by books, notes and manuscripts, lay Morgan on a dirty bed, cared for by an unkempt washer woman.

He was indeed dead.

TH Widely Read

The AMA publication, "Today's Health," has wider readership in Michigan today than a year ago—thanks to the State Library of Michigan. The State Library has a special grant to enrich the local libraries by providing copies of selected periodicals. The Library is providing 328 smaller libraries with a special group of only 39 periodicals and is providing 140 larger libraries with 124 periodicals—and "Today's Health" is in both groups.



The Author

C. Howard Ross, M.D.

* * *

Though John Morgan died in squalor and oblivion, he had fulfilled a further Boerhaave aspiration and became the father of American Medical Education and a sponsor of Medical Communications. We, of this day and age, should learn an acute lesson from John Morgan. By performing an about face, we can fortify ourselves against frustration and learn to disagree on a gentlemanly and scientific basis. When the age of Geriatrics swoops down upon us, we, with wiser choice, can philosophically prepare against the all encompassing onslaughts of "hasbeenism," retaining dignity and purpose in our later years.

I serve today as the earnest champion of our medical hero, who began a distinguished career with such brave intent. It is my ambition one fine day to witness the creation of a bronze plaque dedicated in Philadelphia to his memory, assuaging tardily some spiritual wounds of history.

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From The Mailbag

Dear Editor,

The recent Forum Page discussions about the training of general practice men interests me. My views on this matter in a concentrated form are:

1. The medical student, through his entire training until he finishes his internship, has very little if any exposure to general or family practice type of medical work.
2. His training is all done by highly trained specialists who are inclined at times to belittle a general practitioner's work.
3. The financial returns and feeling of satisfaction for a job well done are just as great, if not greater than the majority of specialists have.

Sincerely,
John R. Heidenreich, M.D.
Daggett

Dear Editor,

The Forum page in the March issue about "How Can the Medical Schools Interest More Students in General Practice?" interested me. I'd like to add some of my views:

To answer this question one must start with the assumption that organized medical education today has a real desire to increase the numbers of general practitioners in this country. If this be the case, then one must realize that the student has to be brought into contact with the general practice field during his early medical training, or before, so that he may have some type of factual information upon which eventually to make his decision for his own medical career. Needless to say, the image of general practice must be improved.

Contact with general practice could first be accomplished by establishment of departments or chairs of general practice in the medical schools, the object of which might well be to acquaint the students in their early preclinical years with some of the scope of a generalist today. Later in the clinical years the actual everyday approach by a physician to treating the person, as well as the family as a whole, could be presented.

In the latter part of medical school I believe that every young medical student would benefit by the proper preceptorship type experience under a qualified man in general practice. Contrary to the arguments against this, I do believe there are enough men in this field who are well qualified and trained and who are willing to take the time to give some of their knowledge and practical experience to these young students. At the same time there are also many hospitals in rural and semirural areas where an excellent brand of medicine is being practiced and where such students could benefit immensely from clerkships or externships.

Finally, there is of course one simple way in which organized medical education could immediately solve the problem of supplying adequate numbers of men to general practice. This would be accomplished by requiring all physicians to complete two years of general practice before they are acceptable for residency training. Perhaps this requirement might be related in some way to a revision of the place of the internship program.

—E. S. Woodworth, M.D.
Howell

Attention: Hugh Brenneman

Glad to mail a check for Michigan Medicine. It is improving with each number.

Thanks for your kind note about my health. I am improving daily. I was not operated upon, but my old pump, after eighty years, became tired and wanted to stop, but modern medicine revived it and God is doing the rest.

Sincerely,
Howard H. Cummings, M.D.
Ann Arbor *(MSMS Past President)*

Medical Writers, Doctors To Hear Researcher

Roger S. Mitchell, M.D., distinguished researcher and educator from Denver, will be the featured speaker at the 1966 MSMS Conference on Medical Reporting, May 5. Doctor Mitchell will present the annual Yates Lecture in the evening. The Conference at MSU Kellogg Center is open for interested physicians and newspapermen. Doctor Mitchell received his M.D. degree from Harvard, then practiced in Glen Falls, N. Y., seven years before entering the Army during World War II. After a residency at North Carolina Sanitarium, he became associated in 1947 with the Trudeau Sanitarium, N. Y., and then went to Denver in 1955. He has served since as associate professor of medicine at the University of Colorado School of Medicine and director of the Webb-Waring Institute for Medical Research there.

1966 Annual Session Schedule Listed for GR

The Program Committee for the 1966 Annual Session (Pantlind Hotel-Civic Auditorium, Grand Rapids) has arranged the following schedule or the Scientific Session:

TUESDAY, SEPTEMBER 27:

Morning	Meetings of Specialty Groups
2:00 to 2:00 p.m.	Luncheon-Meetings of MSMS Sections
2:00 to 5:30 p.m.	General Assembly Lectures and/or Panels
Evening	Meetings of MSMS Sections, Specialty Groups, and Alumni Associations

WEDNESDAY, SEPTEMBER 28:

8:30 to 10:00 a.m.	Round Table Discussions (with continental breakfast)
0:00 a.m. to noon	General Assembly Lectures and/or Panels
2:00 to 2:00 p.m.	Luncheon-Meetings of MSMS Sections
2:00 to 5:30 p.m.	General Assembly Lectures and/or Panels
Evening	MSMS State Society Dinner Dance

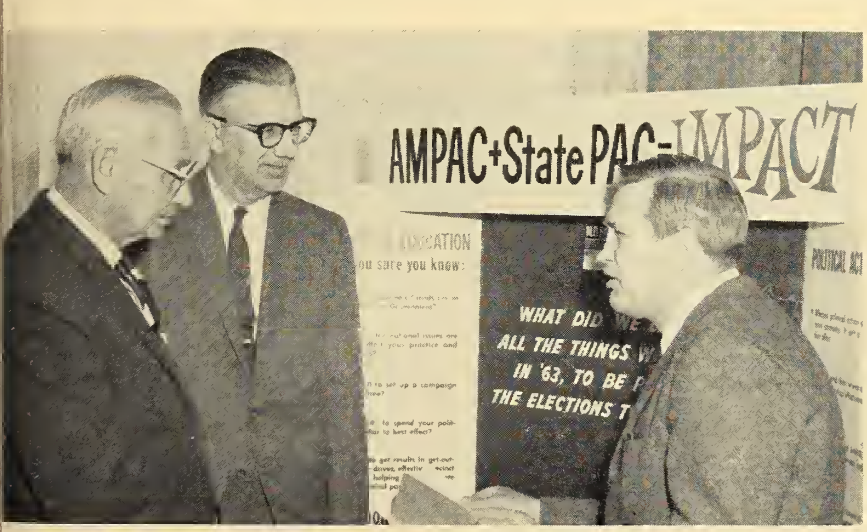
THURSDAY, SEPTEMBER 29:

8:30 to 10:00 a.m.	Round Table Discussions (with continental breakfast)
0:00 a.m. to noon	General Assembly Lectures and/or Panels
2:00 to 2:00 p.m.	Luncheon-Meetings of MSMS Sections
2:00 to 5:30 p.m.	General Assembly Lectures and/or Panels
Evening	Meetings of MSMS Sections, Specialty Groups, and Alumni Associations

FRIDAY, SEPTEMBER 30:

9:00 a.m. and continuing through luncheon	Clinics at Blodgett, Butterworth, and St. Mary's Hospitals in Grand Rapids

Following the theme "Medicine in our Changing World," an outstanding postgraduate program is being arranged for you. The General Assembly speakers and topics, and the subjects of the Round Table Discussions and he names of the participants will be announced in the very near future.



Louis F. Hayes, M.D., right, Workshop Chairman, explains preliminary plans for the MDPAC Workshop, June 5 in Detroit, to MSMS President Luther R. Leader, M.D., left, and President-Elect C. Allen Payne, M.D., center.

List Official Poll Results

The results of the poll of physicians regarding amalgamation was announced March 23 by the State Affairs Committee of the House of Representatives.

It was reported that 68 per cent of the 9,928 physicians who received questionnaires had returned them, and that 89 per cent of the osteopaths responded.

Following is the vote on each of the three questions:

On the question of state support of an osteopathic school, the MD's voted 6,491 no and 230 yes; while the DO's voted 1,424 yes and 102 no.

On the question of amalgamation, 5,520 MD's voted yes and 1,234 no; with the DO vote 195 in favor and 1,338 against.

The third question, dealing with the consideration of staff appointment in "public supported" hospitals on the basis of individual qualifications, whether MD or DO, the vote was MD's, 5,010 yes and 1,705 no; and DO's, 1,442 yes and 76 no.

Call MD-PAC Workshop June 5

The Michigan Doctors Political Action Committee will sponsor a statewide workshop in Detroit, June 5, for representatives from every county medical society and for interested physicians and wives.

The workshop, as a forerunner to the profession's participation in the 1966 election, will begin at 10 a.m. at the Sheraton-Cadillac Hotel, with adjournment at 4 p.m.

State and national elected-officials will headline the program. AMPAC participation will be led by Blair Henninsgard, M.D., Oregon, member of the AMPAC Board.

Louis F. Hayes, M.D., Gaylord, Vice Speaker of the MSMS House of Delegates, and member of the MDPAC Board of Directors, is the workshop chairman; working closely with Dr. Hayes is W. C. C. Cole, Jr., M.D., Detroit, MDPAC Chairman.

Timely Topics At Conference For Officers

(See Editorial page 290.)

The importance of community leadership, effective communications and continuing education were stressed by Harold Sponberg, President, Eastern Michigan University, in his closing address at the 1966 Officers Conference at the Wayne County Medical Society Building.

The conference, February 25-26, had many highlights. The participants praised The Council for presenting timely information about medicare, governmental relations and public service.

The attendance was the best in many years — with 40 of the 55 county societies represented. In the past, about one half attended and the other half did not.

A new feature was a Workshop for County Society Presidents and Presidents-Elect, in addition to Workshops for County Secretaries and County Bulletin Editors. The MSMS Legal Affairs, Public Relation and MD-DO Committees also met on Friday night, February 25.

On Saturday, the morning program dealt with the "Capitol Scene — Lansing and Washington, D. C." Speakers included Otto K. Engelke, M.D., Ann Arbor; James Foristel, LL.B., AMA Representative, Washington; August Scholle, Michigan AFL-CIO President; R. B. Roth, M.D., AMA Council on Medical Service, and Bernard P. Harrison, J.D., AMA Legislative Department.

Awards were presented to nine Michigan physicians who are presidents of national organizations and to C. Howard Ross, M.D., Ann Arbor.

Brock E. Brush, M.D., Detroit, presided in the afternoon for 14 reports of successful county society public relations programs and comments about MD-PAC, the Healthmobile and the MSMS rechartering project. President Sponberg climaxed the conference with his thought-provoking address.

MR. HARRISON
AR SCHOLLE
DR. ROTH
DR. ENGELKE

August Scholle, second from left, Michigan AFL-CIO President, tol the Officers Conference about the mutual goals of medicine and labor Other morning speakers, left to right, were Bernard P. Harrison, AMA R. B. Roth, M.D., AMA Council on Medical Service Chairman, and Ott K. Engelke, M.D., MSMS Legal Affairs Committee Chairman.

The fine facilities of the Wayne County Medical Society headquarter were ideal for the 1966 Officers Conference. The activities utilized th dining room, auditorium, meeting rooms, lounges, and display and registra tion areas.

The many years of enthusiastic service by C. Howard Ross, M.D., center Ann Arbor, as the former chairman of the MSMS Committee on Course on Economics and Ethics, was recognized by a MSMS Citation. The pre sentation was made by Luther R. Leader, M.D., right, MSMS President, anc D. Bruce Wiley, M.D., MSMS Secretary.

ports-Medicine onference Soon

Physicians who are serving as team ctors or who are interested in the edical aspects of athletics are in-ted to a "MSMS Conference on edical Aspects of High School orts" at Ann Arbor, May 19.

The new MSMS Committee on edical Aspects of Organized Ath-tics will sponsor the one-day sem-ar. The Committee urges every mponent county medical society send two or more representatives, r possible follow-up activity on the cal level.

Leadership for the conference is ing shared by James S. Feurig, I.D., Committee chairman and ISU physician; and Gerald A. 'Connor, M.D., Committee mem-er and U-M physician.

NEWS BRIEFS:

He Who Runs May Read That...

SAGINAW — Three county medical societies cooperated with the Michigan Tuberculosis and Respiratory Disease Association to present a "Seminar on Respiratory Disease" at Saginaw recently. Cooperating in the event was the Saginaw County Medical Society, Midland County Medical Society and the Bay-Arenac - Iosco Medical Societies. Michigan speakers included E. Osborne Coates, Jr., M.D., Detroit, and Joseph R. Smith, M.D., Ann Arbor.

DETROIT — The new assistant dean of the School of Medicine at Wayne State University is Thomas A. Bruce, M.D., an associate professor of internal medicine since 1961. Doctor Bruce will be responsible for organizing university outpatient services in the Detroit Medical Center.

FERNDALE — At the recent dedication of the Kingswood Neuropsychiatric Hospital two $2500 fellowship grants in psychiatry were presented to the departments of psychiatry of Wayne State University and the University of Michigan.

Dr. William R. Keast, president of Wayne State University, dedicated the $750,000 100-bed unit.

Bids are now being received for the next phase of the Kingswood Complex, a 150-bed convalescent home and professional building.

DETROIT — Three Detroit cancer control agencies recently merged with the Michigan Cancer Foundation. Michael J. Brennan, M.D., Detroit, was named permanent president of the foundation whose purpose it is to provide a unified attack on cancer problems. A long-range research program aimed at eliminating cancer of the breast is being undertaken by the Michigan Cancer Foundation. Annual physical examinations of 5,000 women over a period of four or five years will be one of the beginning phases of the program.

ealthmobile in W. Michigan; hen Wisconsin and Up North

The MSMS Healthmobile con-nues to draw children, teachers, arents as it visits different com-unities each week.

Following is the schedule for pril:

Grand Rapids, April 1-8
Kalamazoo, April 8-15
Benton Harbor, April 15-22
Holland, April 22-29
Muskegon, April 29-May 5

MSMS then will accept the invi-ation of the State Medical Society f Wisconsin to show the Health-obile at the 125th Anniversary Ieeting at LaCrosse, Wisconsin.

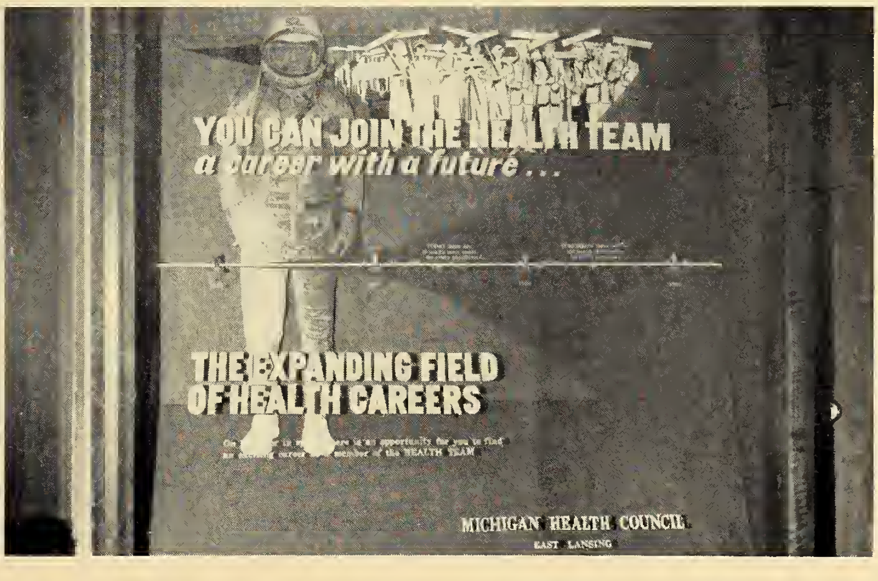
The Healthmobile will appear at ronwood, beginning May 16, and ravel across the Upper Peninsula. ubsequently, the schedule will cover he northern part of the Lower Pen-nsula, and then begin the county airs circuit at Cadillac on August 1.

During March, the health-mu-eum-on-wheels, visited these towns:

Detroit, February 25-March 4
Saginaw, March 4-11
Bay City, March 11-21
Mt. Pleasant, March 21-25
Big Rapids, March 25-28
Greenville, March 29-31

In each case, the County Medical Society and its Auxiliary sponsored the health-museum-on-wheels, with the fine support of the schools, merchants, newspapers, radio and television stations, etc.

The Michigan Health Council exhibit in the Healthmobile appeals to youth—"You can join the health team—a career with a future." Every day, students, teachers and parents take many of the career-recruitment folders from the MSMS Healthmobile.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Cochrane Heads GP Academy

Edgar G. Cochrane, M.D., Highland Park, is the new president of the Michigan Academy of General Practice. He was elected at the 20th annual postgraduate clinic in Detroit in March.

Doctor Cochrane succeeds Fred Brace, M.D., of Grand Rapids.

The new president, a Highland Park physician since 1926, is a past president of the Wayne County Academy of General Practice.

T. J. Trapasso, M.D., Sault Ste. Marie, has been re-elected secretary-treasurer of CAMDA, formerly known as the Canadian-American Medical and Dental Ski Association.

W. L. McCullough, M.D., Petoskey, will help plan the next program at Vail, Colorado, March 19-26, 1967. About 115 attended the recent 1966 conference at Vail.

GRAND RAPIDS — The Kent Medical Foundation recently elected its officers for the year. They are L. Paul Ralph, M.D., who will be serving his second consecutive term as president; Fred G. Brace, M.D., vice president; Carl H. Moberg, M.D., secretary-treasurer; and Roger Warnshuis, executive secretary.

Ross V. Taylor, M.D., Jackson, new president of the Michigan Heart Association (left), chats with Donald B. Effler, M.D., Cleveland, at the recent annual Scientific Session of MHA in Detroit. They also participated in a public forum on "Arteries and Your Heart" at the Ford auditorium.

MSMAS Seminar Set April 26

Medical assistants are invited to the 1966 Educational Seminar of the Michigan State Medical Assistants Society at Bay City April 24. The meeting will be held at Le Chateau with housing at the Empire House Motel.

Addresses will be given by Robert M. Heavenrich, M.D., Saginaw; John L. Shek, M.D., Bay City, and Z. E. Taheri, M.D., Bay City.

AMWA to Confer In Detroit Soon

The Michigan Chapter of t American Medical Writers' Associ tion will hold its annual meeti April 27 at the Hotel Pontchartra in Detroit. Activities will begin 6:15, with a dinner at 7:00, f lowed by a short business meeti and election of officers at 8: Russell N. DeJong, M.D., is charge of the nominating committ

A panel on editing and a pan on communications will be he with a general discussion followi them. For further information wri to C. Howard Ross, M.D., 180 U derdown Road, Ann Arbor, Mich gan.

Pathologists Pick Michigan Doctor

ANN ARBOR — A. Jam French, M.D., chairman of th Pathology Department in the Un versity of Michigan Medical Scho is the new president of the Intern tional Academy of Pathology.

He will lead the 2,850-doctor o ganization for the next 12 mont and direct its congress in Octob in Kyoto, Japan. The 60-year-o academy draws most of its membe from North America, Europe an Asia.

This panel presented a program at the "Joint Meeting of the Wayne County Medical Society with the Clergymen" on March 7 in Detroit. Left to right are Rev. Erwin A. Britton; Mario A. Petrini, M.D.; Rabbi Leon Fram; Warren W. Goodwin, M.D.; F. P. Rhoades M.D.; John W. Moses, M.D.; Very Rev. Msgr. Wm. G Sherzer; Leon A. Dickson, M.D., and Very Rev. Thoma Ruffin.

SEPARATE BILLING BY HOSPITAL SPECIALISTS

By Ben R. Van Zwalenburg, M.D.
Grand Rapids
President, Detroit Roentgen Ray and Radium Society

One result of the medicare program may well be a lefinite check on the trend toward hospital dominaion of medical practice.

If this happens, it will result from success in the fforts of the "hospital-based specialists," the radilogists, pathologists, anesthesiologists and physiatrists, regain the same basis for practice as other mem-ers of hospital medical staffs. Their success will deend directly upon the support they receive from their llow physicians at the local level.

Most doctors are accustomed, within reason, to xing their fees and being responsible to their patients r payment. This has not been the general pattern ithin these four specialties. The convenience of one ill for in-hospital diagnostic services, and the relief f the specialist from the chores of collecting, took on n onerous overtone when the hospital authority egan to regard him as an employee.

The first medicare bills made it clear that the Fedral Government, with the encouragement of the merican Hospital Association, was ready to regard hese specialties as hospital services. The successful truggle of the specialty groups and the AMA to have ll doctors covered under a voluntary medical plan is ne of the few bright spots in the whole affair. Conressman Wilbur Mills of Arkansas heard the medical oint of view, accepted it and stood fast against vast ressures from the hospitals and from organized labor.

The medicare law, as finally passed, reflected the olicy of the AMA regarding these specialties. It did ot reflect the current relationship between the AMA nd hospitals, except for anesthesiologists, who began vigorous campaign to disengage themselves 10 years go, so that most anesthesiologists now bill their atients and collect their own bills.

In radiology and pathology, most specialists connued to allow their hospitals to collect for their rvices and to retain a part of the fee, though clearly n violation of ethical prohibitions against fee splitting nd corporate practice.

Now, even without the Douglas amendment, the edicare implementation policies, as announced, try play down the intent of Congress by regulations to ccommodate hospital contracts. Thus the leaders of e colleges are aware that their members, and ultiately all medicine, will remain in peril until hospital contracts are no longer the common arrangement. Their policy, therefore, calls for their members to end their contracts and begin billing patients for their professional services exactly as other physicians do.

The colleges have done much to help their members solve the problems involved in changing their way of practice. But as one radiologist observed, "not a single contract is ended in our meetings. Each one must be ended by a determined radiologist (or other specialist) who means to practice ethical medicine and who has the firm backing of his medical staff."

In recent years hospital leaders have begun to refer to their institutions as "citadels of health care." In some contexts, there is no argument. But, as used by the AHA, the phrase implies that the hospital has superseded the individual physician as a patient's primary source of health care. This viewpoint is not acceptable to the medical profession.

Now, with the determination of the "hospital-based" specialists that their services shall be provided *in* hospitals but not *by* hospitals, the movement will be checked. How effective this check will be depends upon the success of the individual specialists in reaching satisfactory new bases for practice in their hospitals. Their success, to a great extent depends upon the support locally of all their colleagues in medicine.

If they lack this support they will not succeed. And after they are taken over, which others will be next?

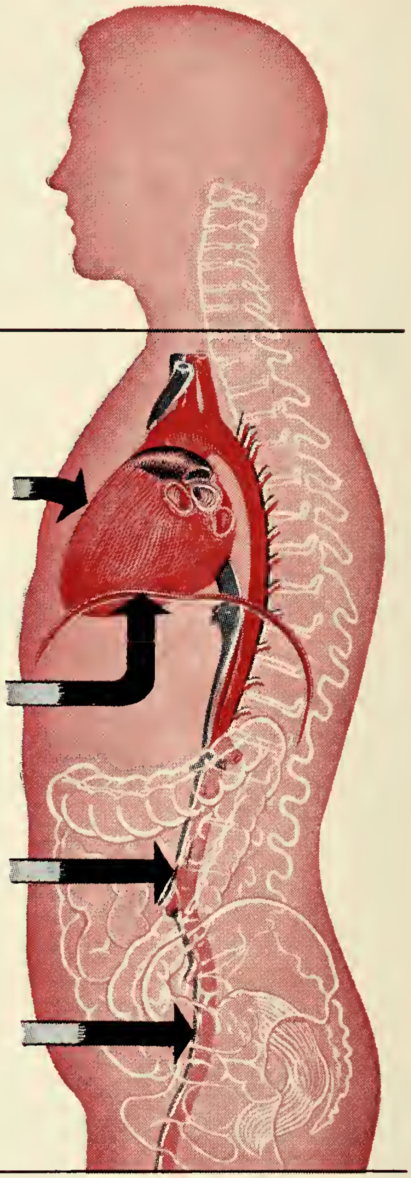
ON GIVING THEM WHAT THEY WANT

By Dean P. Carron, M.D.
Ann Arbor

What do you mean it is difficult to be Program Chairman? Just give them what they want and they will be there. Ah, "there's the rub." What do they want?

A number of years ago Washtenaw County Presented the typical postprandial supplement. A high level specialist, the county boasts many among its members, or a visiting "name" would wax eloquently. "Great talk, too bad more people didn't come out. It was nice to see Dr. - - - - - (same field of specialization as the speaker). Haven't seen him at a meeting

(Continued on Page 288)



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for years." Then the program chairman started a new idea. "Enough scientific talks," he said. "We have our fill of these at the numerous hospital and medical school meetings and conferences. Medical-social-economic problems, that is what we have to present; we must be better informed." The first year this was a terrific idea. Attendance at meetings went up. The Bulletin editor wrote: "What a success! This spells the end of scientific programs." The second year meeting attendance dropped a little bit more month after month. Now what's wrong? "Still too much medicine; we get all that stuff from AMA and MSMS and now we have to hear it at the meetings too," are the comments. Well that is simple, the programs the next year consisted of talks on unusual travel, fishing, sports, etc. How was the new attendance—just fair, just fair.

The next year the program chairman is more shrewd. A questionnaire asks—what kind of a program do you want? Do you come to the evening meetings? If not, why not? What will it take to get you to a monthly meeting? What are the answers? Yup—you guessed it. "If you had a good scientific program, I would come." "I can't waste an evening on that drivel, give me a good scientific paper." So this year there will be something of this and something of that. The Program Committee is hoping that a doctor will not feel that he is contaminated if he actually listens to a scientific talk that is outside his special field of interest. Some of the programs will appeal to the doctors' realization that he is a citizen as well as a doctor and interested in the general public health and welfare. And now and then the doctor will have to hear the political facts of life.

It's not hard to be program chairman, just give them what they want. What do you want?

CONTINUING EDUCATION

By James J. Lightbody, M.D., Speaker
MSMS House of Delegates

"Therefore be it resolved that in this our MSMS Centennial Year, every member of the Michigan State Medical Society be urged to attend and participate in one or more of the continuing education programs which are offered this year."

This resolution, No. 42, was adopted by the MSMS House of Delegates at the Centennial Session in Detroit last September.

On another page of this issue of MICHIGAN MEDICINE, the 1966 Spring MSMS Postgraduate Calendar is announced. The calendar lists an excellent series of afternoon hospital clinical programs and evenin lectures, offered again by the fine MSMS Postgraduate Education Committee in cooperation with the medical schools and the state department of publi health.

The spring series offers an excellent opportunit for Michigan physicians to participate in another continuing educational experience.

You are urged to attend.

WILL PHYSICIANS ROLL WITH THE PUNCH?

By Robert J. Mason, M.D.
Vice Chairman, MSMS Council

A few short months ago a special conference wa held at the White House between representative of American medicine and various federal officials The discussion concerned Medicare. The Presiden turned to Wilbur Cohen and said, "I understand you have been giving these doctors a hard time, now I want you to start co-operating with them."

Thus our adversary has again been spotlighted Mr. Cohen, Under Secretary of HEW, is the chie architect of current social legislation. Thirty year ago he was one of the original drafters of the Socia Security Law and ever since, guided expanding federal welfare regulations. He is the chief strategis in concocting all major Medicare legislation.

In an exclusive interview on what Medicare wil mean to physicians as reported in Medical World News, 6 August 1965, Mr. Wilbur J. Cohen made the following direct statements:

"I don't look upon this new legislation as a step towards socialization of medicine."

* * *

"There is absolutely nothing in the bill that gives the government any right to determine the kind of medical care that the practitioner may or may not give to the patient."

* * *

"We are going to try to do everything we can to expand skilled nursing homes, home health services, outpatient diagnostic services, and utilization review committees in hospitals. All of these will mean earlier access to medical care, higher quality of medical care, and it will mean that more people will get better medical care. But at the same time, it can all be done in a way that will not intervene in the doctor's practice."

* * *

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comments by the drafter of the Medicare bill, certain logical truisms must be reiterated over and over again.

1. Historically, those countries with a socialistic tendency have tried "the foot-in-the-door" technique in controlling certain segments of medical practice, and ended up with full blown governmental control.

2. The overseer who holds the purse strings will eventually dictate the rules and regulations of procedure. Since the Bill states that the government will pay only certain designated hospitals for Medicare patients, many doctors will be denied access to their own private patients.

3. The American physician is dedicated to only one principle, *quality* Medical care for his own patient.

"In the market place" of Washington Legislative Halls, the American Physician has been bartered (even drawn and quartered). But those architects of socialistic legislation seem to have forgotten one factor in their bartering—only the physician is the purveyor of medical service and care. This is his heritage and privilege and responsibility.

Physicians will devise an honorable way to roll-with-the-punch from a bureaucratic fist and continue to purvey quality care.

SELF-RENEWAL

Robert D. Calkins, president of the Brookings Institute, said it: "Professional self-renewal has become a requirement for the preservation of competence in almost every profession."

The professional man must continue to pursue knowledge throughout his life for four basic reasons, Calkins said. They are: Rapidly changing social conditions, new qualifications for career advancement, the changing nature of occupations, and the need for more sophistication in the conduct of private affairs.

NINE LEADERS

Proof that Michigan physicians are highly regarded in the nation is the fact that nine Michigan doctors of medicine are serving today as presidents of national medical organizations.

Each year, the Michigan State Medical Society recognizes these members with special "President's Awards." These awards are being presented this month at the county medical society meetings, or at the MSMS Officers Conference.

In the past five years, Michigan physicians have

WHEN THE CLINICAL SITUATION CALLS FOR VITAMIN A—

in vitamin A deficiencies such as acne and other hyperkeratotic dermatological disorders, certain ophthalmic conditions and disorders in which absorption or utilization of fats and fat-soluble vitamins may be impaired.

rved as presidents of 25 national medical and ealth organizations, according to Luther R. Leader, .D., president of the state medical society.

Physicians now leading the research and educa-ional activities of their national organizations in-lude the following, alphabetically:

William H. Beierwaltes, M.D., Ann Arbor, So-iety of Nuclear Medicine;

John A. Cowan, M.D., Lansing, Association of tate and Territorial Chronic Disease Program Dis-ricts;

Arthur C. Curtis, M.D., Ann Arbor, American enereal Disease Association;

Winthrop N. Davey, M.D., Ann Arbor, American Thoracic Society;

Reed O. Dingman, M.D., Ann Arbor, Foundation f the American Society of Plastic and Reconstructive urgery;

Jacques S. Gottlieb, M.D., Detroit, American oard of Psychiatry and Neurology;

Jackson E. Livesay, M.D., Flint, elected in February to head the American College of Radiology;

Kenneth R. Magee, M.D., Ann Arbor, Society of Clinical Neurologists;

J. Robert Willson, M.D., Ann Arbor, Association of Professors of Gynecology and Obstetrics.

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IS YOUR ESTATE RISING?

By W. Fred Mangan, Vice-President
Professional Management
Black and Skaggs Associates
Battle Creek

Financial progress can't be measured in terms of income alone. This article may spur you to total up the true picture of your assets . . . your net worth.

It is a common question to be asked, "How am I doing?" At the end of the year my usual answer is: "I'll be able to tell better after I've gone over all details of income and expenses and what you own and owe. Your income looks pretty good. But it's your net worth picture I want to study."

I recently said just that to a new client whom I'll call Dr. A. A. Sample. He's so typical of thousands of doctors that I think you'll be interested in following through on our conversation.

Dr. Sample is a general surgeon in western Michigan. His net pre-tax income has exceeded $25,000 for nearly 20 years. Today, though, he's worth only about $50,000. That's what he would realize if he sold all he owns, including his home.

"And that's what worries me," he explained. "I have a reasonably good income, but I don't accumulate any money. If my income should fall off, where would I be? This isn't a matter of estate planning, you understand. If I were to die, my family would be well fixed. I carry a good load of insurance, most of it bought years ago. My premiums add up to $2,700 a year, and the cash values are building up nicely. But I just don't get ahead as other men netting $25,000 a year seem to."

* * *

WHAT WAS BOTHERING Dr. Sample was his net worth—the difference between what he owned and what he owed. There wasn't enough difference, he felt, even though he was apparently rich in possessions.

Dr. Sample lives in a large house with ample furnishings. At his office, he has much costly medical equipment. He has two cars, a boat, and a one-third share in an airplane. All these possessions, when new, were worth about $100,000. But Dr. Sample still owes nearly $20,000 on them, and another $30,000 of their original value has vanished in depreciation. So his possessions don't really make him rich.

Using the data he'd given me, I made up comparative net worth statements for 1960 and 1965. You can see them for yourself on Table I. They tell you one vital fact about the doctor:

Table 1
A Net Worth Work Sheet for A. A. Sample, M.D.

	12-31-60	12-31-65
Assets		
Cash in office bank account	1,800.00	2,100.00
Home bank account	500.00	500.00
Cash in savings account	400.00	1,600.00
Office equipment	200.00	900.00
Motor boat	4,900.00	5,700.00
Airplane (share)	—0—	900.00
Residence	54,500.00	60,000.00
Home furnishings	—0—	2,400.00
Other assets	10,000.00	4,000.00
Total Assets	72,300.00	78,100.00
Liabilities		
Reserve for taxes	1,800.00	2,150.00
Mortgage payable	18,000.00	8,400.00
Improvement loan	—0—	6,000.00
Auto Loan	800.00	1,000.00
Loan for taxes	2,000.00	1,000.00
Total Liabilities	22,600.00	18,550.00
Net worth beginning of year	49,300.00	55,800.00
Add gain (or loss) during year	400.00	3,750.00
Net worth end of year	49,700.00	59,550.00
Total Liabilities and Net Worth	72,300.00	78,100.00

* * *

ASIDE FROM THE annual increase in his equity in his home, his net worth was not much more in 1965 than it was in 1960. In terms of purchasing power, his net worth at the end of 1965 (if he had turned it into cash) would probably have bought no more than his smaller net worth would have bought at the end of 1960.

"Is there any formula that will tell me how much my net worth should increase each year?" Dr. Sample wanted to know.

I had to admit that, so far as I knew, there wasn't. "But I can tell you what some other doctors average in this direction," I said. "For years now, my firm has kept tabs on the annual net gain of several thousand physicians in various income brackets. I'll review our latest net worth table with you. It will give you an idea of what can be done, so you'll have a goal in mind."

The chart I showed him is reproduced in part on Table 2. From it, you can see how much below average Dr. Sample's annual net gain is. If Dr. Sample had notched the average net gain for his income bracket, his net worth would have risen at least

$25,000 during the past five years. And this doesn't include his life insurance cash values.

In case you're puzzled by this exclusion, I'll explain now why our organization omits two items in a client's net worth statement: the cash value of his life insurance, and the value of his accounts receivable. Life insurance is something the doctor buys for his family, not as an addition to his personal resources; and patients' unpaid accounts aren't realizable at will, as other assets are.

As I pointed out to Dr. Sample, he can cash in on his life insurance policies only by leaving his family unprotected, and he can cash in on his accounts receivable only by giving up his practice.

* * *

WHY HAS DR. Sample's net worth lagged behind?

His trouble is that he spends too much on things that have a purely "consumer value" or a rapidly depreciating value. Some examples:

In 1965, his living expenses for a family of four amounted to $16,000. The Samples are hardly ever home. Their winter vacations, weekend trips, parties at the country club, and the live-in maid cost the doctor a cool $4,000 a year. (I discovered this when going through his check stubs to make up the net worth statements).

Table 2

Net Pre-tax Income	Net Gain	Net Gain % of Incom
$10,000.00	$ —307.00	—.3%
15,000.00	1,511.00	10.0%
20,000.00	2,472.00	12.5%
25,000.00	3,625.00	14.5%
30,000.00	4,764.00	16.0%
35,000.00	6,184.00	17.5%
40,000.00	7,550.00	19.0%
45,000.00	8,582.00	19.0%
50,000.00	10,746.00	21.0%

Source: 1964 PM Statistics

Last year, too, he bought a new car for persona use, as he does every year. The new car, he told me was "a steal" at $5,400. Said he: "I bought it i October, the week before the new model came out Its list price was $7,000." It's included in his 196 net worth statement as a $4,500 asset—at cost les depreciation. You'll also find among his liabilities little item of $1,000 for an auto loan—the amoun he borrowed to pull off his "steal." (For professiona use, he has a tiny foreign speedster. It's been depreciated down to $1,200.)

The fact is that Dr. Sample "consumes" all his income except for what he invests in his home. He' been doing this for years. He hasn't yet made the discovery that so elated Samuel Pepys in the Sixtee Sixties, when he confided to his diary: "This year

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or the first time, my gettings have exceeded my pendings.”

* * *

IF, LIKE DR. Sample, you’re troubled by the isproportion between your earnings and your true ubstance, here are a few simple suggestions you may ant to follow:

1. Tabulate now (as of January 1) all you own and ll you owe. The difference between these two figures s your present net worth.

2. Multiply your present annual income by five to et a net worth target to shoot for. (When you reach he goal, your idea of its adequacy will have changed. ver the last two decades, the buying power of the ollar has been halved. It has happened before, and can happen again.)

3. Look up the average net gain of doctors in your ncome bracket as shown in the table on Table 2. Reolve that in 1966 you’ll increase your net worth by t least this much. How? By acquiring assets—paricularly assets that appreciate, such as land, buildngs, securities, even cash lent out at interest.

4. Maintain a relationship in kind between your ssets and your liabilities. For example, don’t tie up ost of your assets in a hard-to-get-rid-of home at he same time that you’re incurring large liabilities or, say, cash loans that can be called in 90 days. Try to cover any loan liabilities you take on with assets that can be quickly converted into cash if the need should arise.

5. Try to keep a balanced distribution of your net worth—one-half in real estate, one-fourth in cash or its equivalent, and one-fourth in other forms of investment. One way to come close to this: Match your home equity increase each month with an equal amount divided between savings (or fixed-return investments) and “risk” investments like common stocks or shares in local business ventures.

6. Whenever a clash arises between a “consumer” purchase and your net worth program, solve it in favor of net worth if you possibly can. Once your net worth is rising on schedule, it will be easier for you to splurge—occasionally.

Shield Rolls Up

Membership of the 85 Blue Shield Plans in the United States, Canada, Puerto Rico, and Jamaica increased 1,029,265 during the first three quarters of 1965 to a record 57,286,041.

The National Association of Blue Shield Plans reports that during the first nine months, membership gains were registered by 63 Plans, 20 had losses, and two remained the same.

Gains totaled 1,340,577, while losses amounted to 311,312.

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NEW FROM TUTAG for prompt, comfortable diuretic action with a balanced excretion of sodium chloride and a lower potassium loss under normal dosage and diet regimen

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.
In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.
DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.
PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.
WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.
CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.
Before prescribing or administering, read the package insert or file card available on request.
Available as 25 or 50 mg. scored tablets.
Request clinical samples and literature on your letterhead.

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INCOME AVERAGING MIGHT HELP YOU SAVE

(Prepared by The American Institute of Certified Public Accountants in cooperation with The Michigan Association of Certified Public Accountants.)

Taxpayers who had a larger-than-usual income in 1965 may gain a significant tax-saving by using the income averaging provisions of the Revenue Act of 1964.

While previous averaging provisions applied to a limited number of individuals with certain types of income, the new law is more generally applicable.

It can result in a real tax saving for those with "moderate" incomes in the nature of salaries, commissions, bonuses, interest, dividends, professional fees, ordinary income from sole proprietorships or partnerships and the like. Moreover, no recomputation of prior years' taxes is required.

The income averaging provisions are complex and this discussion is not meant to be exhaustive. In the event you feel that you will benefit from the new law, you should see a qualified consultant such as a certified public accountant, or contact the nearest office of the Internal Revenue Service.

Briefly, income averaging permits a part of the larger-than-usual amount of taxable income earned in a particular year to be taxed in lower brackets, thus resulting in a reduction of the overall amount of tax due. "Taxable income" is income less the deductions (itemized, standard or minimum standard) and exemptions you would ordinarily report and claim if you were not using the averaging method.

ELIGIBILITY

The first test is one of *citizenship*. For 1965—the "computation year"—and for 1961-64—the "base period"—the taxpayer (and his wife, if married) must have been a citizen of the U. S. Also, he (or he and his wife) must have furnished 50 per cent or more of his support during the base period.

The second test is the *income test*. To qualify under this test your "averagable income" for 1965 must be more than $3,000. Using a fictitious Mr. Smith as an example, here is how "averagable income" is arrived at:

First Mr. Smith computes his "adjusted taxable income" for the computation year and the base period years. "Adjusted taxable income" is your taxable income increased or reduced by various adjustments, if any (discussed below). These adjustments are made only for the purpose of determining how to compute your tax under the averaging method.

Mr. Smith determines his "adjusted taxable income" for each of the years 1961 through 1964 as $4,000, $5,000, $7,000, and $8,000. In 1965, it was $18,000.

His average income for the base period was $6,000 (the total of $4,000, $5,000, $7,000 and $8,000 divided by 4). Under the requirements, he increases the $6,000 by one-third (133⅓ per cent or 4/3 of $6,000) and the result—$8,000—he subtracts from his 1965 income of $18,000.

Thus, his averagable income is $10,000 ($18,000 minus $8,000) which is more than $3,000, qualifying him for income averaging. He may elect income averaging at any time prior to the expiration of the period prescribed for filing a claim for refund or credit for 1965. He may also change his election at any time within that period.

"ADJUSTED TAXABLE INCOME" FOR 1965

To compute his "adjusted taxable income" for 1965 Mr. Smith has to first find his taxable income and then subject it to certain adjustments which are part of the tax averaging provisions.

To arrive at his 1965 taxable income he first takes his total income from line 9, page 1, Form 1040, and adds it to his net earned income from sources outside of the United States and net income from sources within United States possessions, if he had such income.

The latter income, otherwise excludable from income tax, is included in taxable income for purposes of averaging only. The standard deduction, minimum standard or itemized deductions and also his exemptions are then deducted in computing taxable income line 11 (d), page 1, Form 1040. The Optional Tax Tables may not be used.

Once Mr. Smith ascertains his taxable income, he then *reduces* it by certain adjustments, if any, to arrive at his "adjusted taxable income" for 1965.

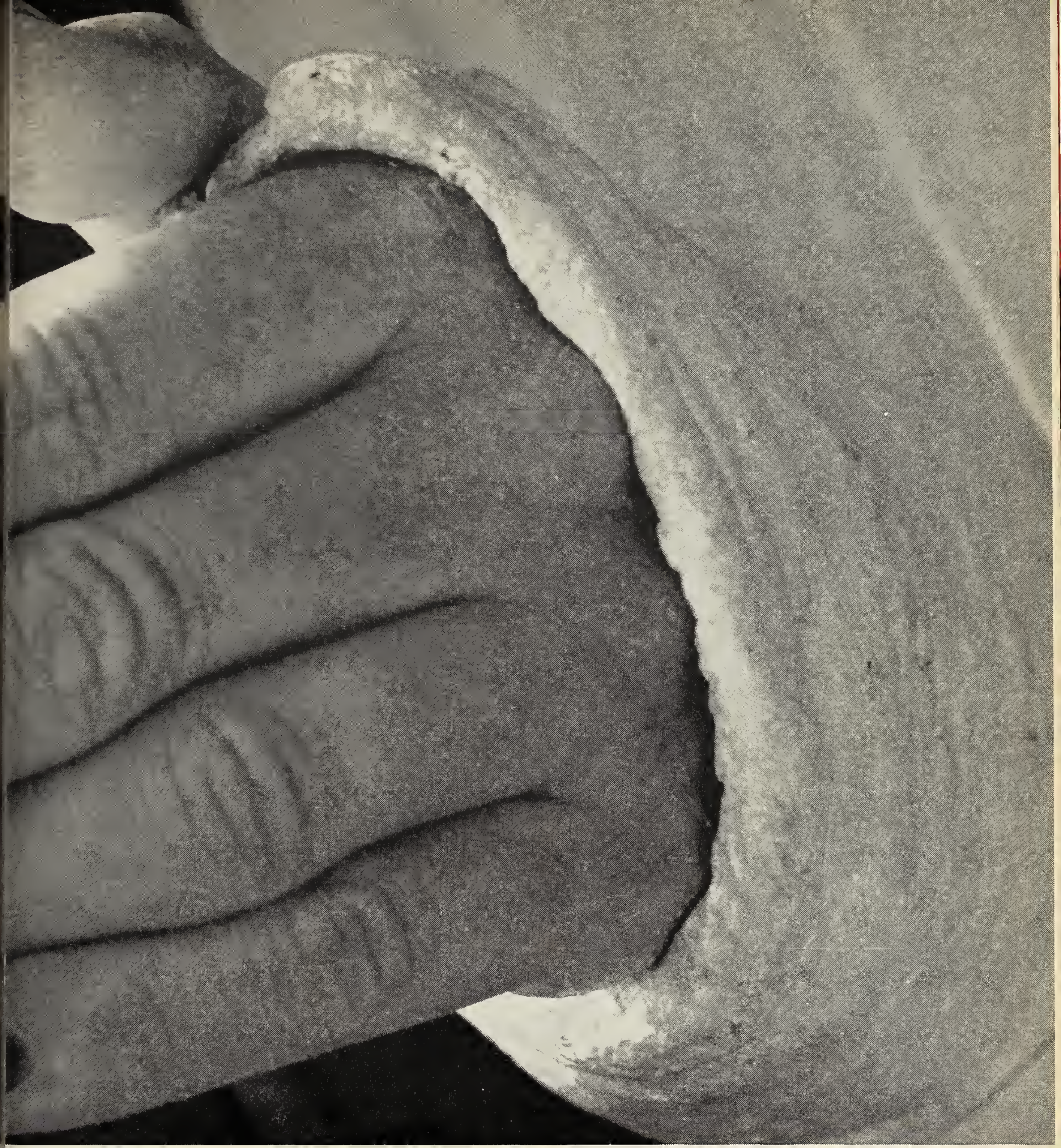
Generally, these adjustments include: (a) capital gain net income for the computation year (i.e., 50 per cent of net long-term capital gain over net short-term capital loss); (b) income attributable to gifts, bequests, devises or inheritances (if such income exceeds $3,000 and the interest in the property was received in the computation year or base period year); and (c) net wagering income.

"ADJUSTED TAXABLE INCOME" FOR 1961-64

In determining his "adjusted taxable income" for the base period years, Mr. Smith finds it different than figuring his adjusted income for 1965.

First, he determines his taxable income for each year by subtracting the standard deduction, minimum standard or itemized deductions, and exemptions. Unlike the computation year, foreign income is not included in figuring taxable income for base years.

Taxable income is then adjusted by adding net income from outside the U. S. and U. S. possessions and reducing it by the other adjustments, except that Mr. Smith doesn't subtract income attributable to



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tress formula vitamins are a key factor in bone and tissue regeneration. To meet the ncreased metabolic demands, STRESSCAPS offers therapeutic amounts of B and C itamins as an aid to smoother convalescence and earlier rehabilitation. In fractures, s in many other conditions of physiologic stress, STRESSCAPS vitamins are therapy.

Each capsule contains:

Vitamin B_1 (Thiamine Mononitrate)	10 mg.
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Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
Calcium Pantothenate	20 mg.

Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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Vials: 10 cc., singly and in boxes of three.
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(Each cc. of NUMORPHAN* contains 1.5 mg. oxymorphone as the hydrochloride.)
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*U. S. Pat 2,806,033.

gifts, bequests, devises or inheritances if he didn have such income in 1965. Also, no adjustment required in a base period year for wagering income.

COMPUTING THE TAX

To provide a relatively simple example of how t compute the tax, we will assume that Mr. Smith ha no adjustments beyond the figuring necessary fo determining his "taxable income."

In this case, he computes his tax on two figures– his "average income" of $8,000 ($6,000 x 4/3) an his "averagable income" of $10,000.

First, he finds his tax on the $8,000, which amount to $1,630. Next, he divides the $10,000 by 5. Th resultant $2,000 is then added to the $8,000 and th tax on the resulting $10,000 is computed. From thi result, Mr. Smith subtracts the tax on $8,000 an arrives at a levy of $560 on the $2,000.

He multiplies the $560 by 5 for a total of $2,800 This added to $1,630 gives him a tax liability o $4,430. This is a saving of $740 from a liability o $5,170 which would have resulted if he had used th regular method.

COMPUTING THE TAX WHERE ADJUSTMENTS ARE MADE

If Mr. Smith had had the income averaging adjustments, his computation would have been much more complex and we will not attempt to do it here.

Briefly, he would have had to compute the tax on the various categories of his adjusted taxable income as follows: (1) 133⅓ per cent of average base period income; (2) excess of average base period capital gain net income over capital gain net income for computation year; (3) capital gain net income for computation year which is less than or equal to average base period capital gain net income; (4) one-fifth of averagable income (then multiply the tax by 5); (5) income from gifts and inheritances; and (6) excess of capital gain net income for computation year over average base period capital gain net income.

In effect, the sum of the tax on all categories would be his total tax liability for the computation year.

Predict Faculty Needs

The number of full-time faculty in U. S. medical schools increased from 3,933 in 1950-51 to 15,514 in 1964-65, according to the Association of American Medical Colleges.

In an AAMC study of trends, it was predicted that there would be 23,000 full-time faculty members in 1970. This was based on the increase during 1960-65.

A projection to 1975 on the same basis would indicate the need of 28,000 full-time faculty members.

These projections, points out the AAMC, do not ake into consideration the new medical schools vhich will be coming into operation during this eriod or the likelihood of expansion.

State Taxes Payable by An Employer With One Employee Earning $100 Per Week First Subject in 1966, No Layoffs

Year	Taxable Wages	Contribution Rate	Contributions (State)	Reserves on Applicable Computation Rate	
				Amount	Percentage
1966	$3,600	2.7	$97.20	$70.20	1.95
1967	3,600	2.7	97.20	194.40	5.4
1968	3,600	2.2	79.20	273.60	7.6
1969	3,600	0.6	21.60	295.20	8.2
*1970	3,600	0.4	14.40	305.60	8.49
*1971	3,600	0.4	14.40	320.00	8.89
*1972	3,600	0.4	14.40	334.40	9.29
*1973	3,600	0.2	7.20	341.60	9.49
*1974	3,600	0.2	7.20	348.80	9.69
*1975	3,600	0.2	7.20	356.00	9.89
*1976	3,600	0.2	7.20	363.20	10.09
*1977		0.1	3.60		

*Contributions after 1969 would be subject to Emergency Contributions ranging from 0 to .6 per cent. Our projections indicate that this contribution, now 0.6 per cent, will be reduced or eliminated by 1967.

No Federal Tax payable under present law. However, extension of coverage and increase in maximum taxable wage to at least $3,600 are likely, with a Federal Tax rate of 1.55 per cent at present tax base of

$3,000, Federal Tax would be	$16.50
3,600	19.80
4,200	23.80
5,000	27.50

Michigan Illegitimate Live Births

Year	Number	Ratio[1]	Rate[2]
1900	332	7.6	1.5
1905	444	9.5	**
1910	1,054	16.4	4.0
1915	1,363	16.8	**
1920	1,445	15.7	5.0
1925	1,258	12.7	**
1930	1,600	16.2	4.2
1935	2,194	25.1	**
1940	2,280	23.0	5.0
1945	3,485	31.2	**
1950	4,425	27.6	11.0
1951	4,367	25.3	**
1952	4,513	25.4	**
1953	4,770	26.1	**
1954	5,610	29.2	**
1955	5,883	30.0	**
1956	6,494	31.5	**
1957	6,789	32.6	**
1958	6,816	33.6	**
1959	6,729	33.9	**
1960	7,200	36.9	16.4
1961	8,017	41.6	**
1962	7,998	43.8	**
1963	8,769	49.0	**

[1] Ratios expressed as the number of illegitimate live births per 1,000 total live births.

[2] Rates expressed as the number of illegitimate live births per 1,000 unmarried women 15-44 years.

**Not available.

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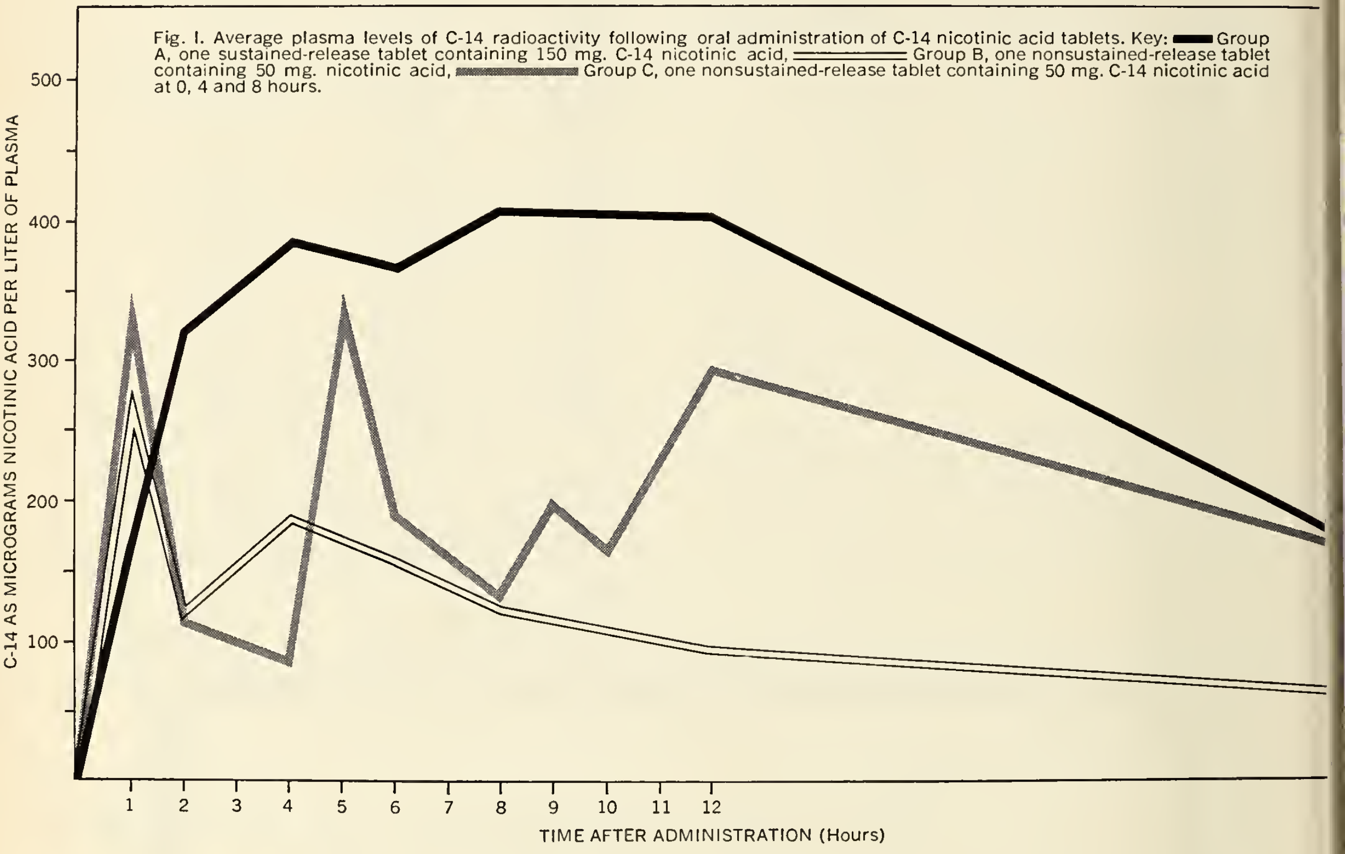

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be co tinuous on a daily dose of only one Geroniazol TT ta let every 12 hours.

The gradual release of nicotinic acid in Geroniaz TT will provide the well-known peripheral vasodilat tion needed in patients with deficient circulation an with a minimum amount (if any) of "flushing." Als cerebrovascular circulation is complemented by pe tylenetetrazol, long-established as a cerebral and res piratory stimulant.

Geroniazol TT improves the typical, unfortunat signs of senile confusion. Patients become more aler

ed and debilitated

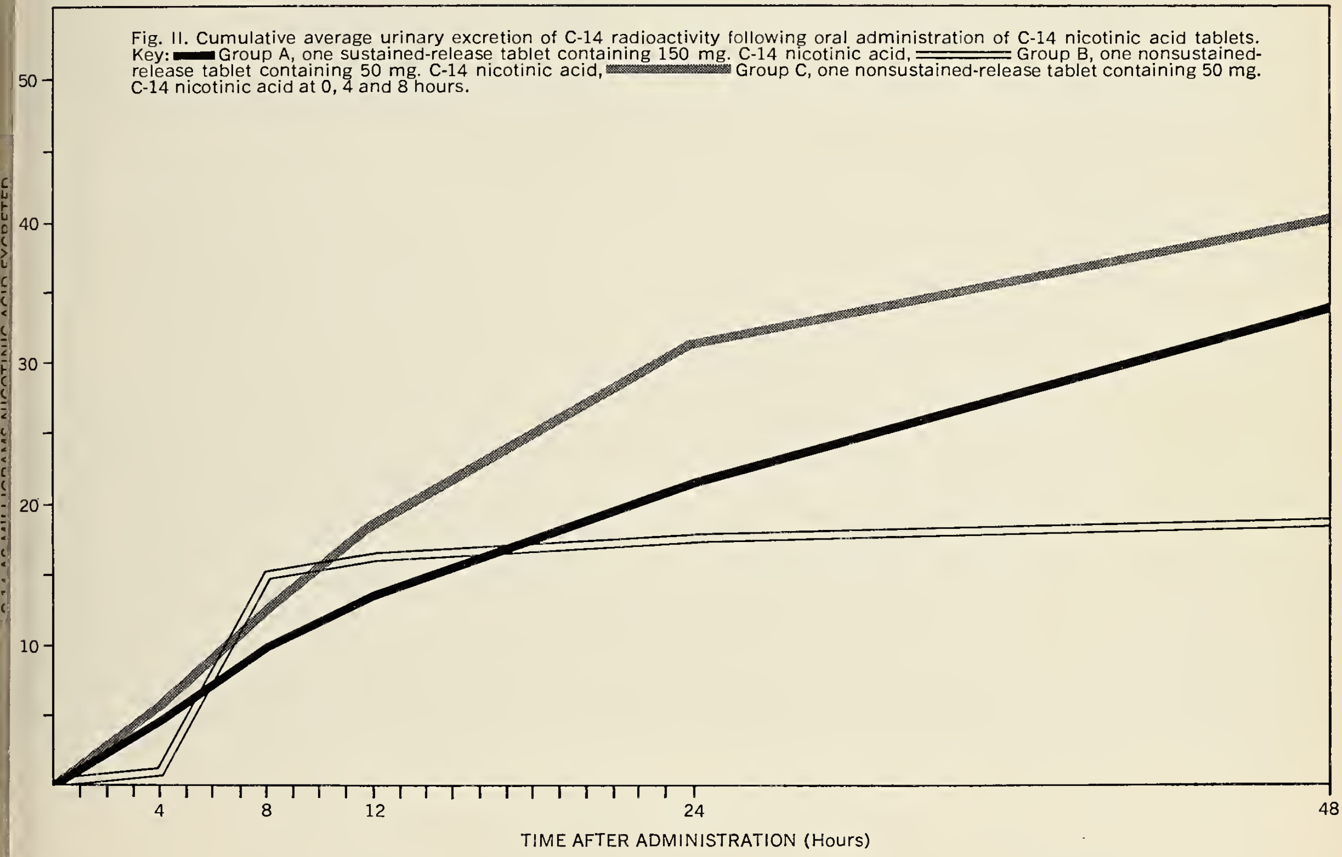

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ss confused and moody. Personal care, memory, otional stability, social attention improve. Fatigue, athy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will rmit your patients to enjoy the benefits of time-olonged nicotinic acid/pentylenetetrazol therapy, an economical price. Dosage is only one tablet every hours.

ontraindications: There are no known contraindications.

recautions: Exercise caution when treating patients ith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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Geroniazol® TT
nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

Subjects Chosen For AMA Session

Population expansion, a subject much discussed in both medical and lay circles, will be one of the major topics presented in general scientific sessions at this year's Annual Convention of the American Medical Association.

The convention is to be held in Chicago June 26-30; the Scientific Program will be at McCormick Place, and the House of Delegates will convene at the Palmer House.

Scientific Sections of the AMA Council on Postgraduate Programs taking part in the General Meeting on population expansion will be Preventive Medicine, General Practice, Internal Medicine, Obstetrics and Gynecology, and Pediatrics. The General Scientific Meetings are open to all physicians attending the Annual Convention.

Other General Scientific Meetings on this year's Annual Convention program will be on the subjects of: emphysema, burns, mysterious fevers, community hospital coronary care units, and headache.

In addition to the General Sessions, each of the 23 Scientific Sections will present scientific programs. Many of the section programs will, as in past years, be joint meetings of two or more sections and, in some instances, a specialty society.

Plan June Seminar On Marriage Counseling

Arrangements for the Seminar on Marriage Counseling, sponsored by the Michigan Society of Psychiatry and Neurology, are proceeding according to schedule.

The scientific portion of the program will begin in the morning of Saturday, June 4, and will close in the afternoon of Sunday, June 5. The official host is the Boyne Highlands Resort Inn at Harbor Springs. Reservations for accommodations must be made directly with the Boyne Highlands Resort Inn. Admission to the sessions will be by badge only, and advance registrations must be made through the Department on Postgraduate Education, Michigan Society of Psychiatry and Neurology, 1600 North Michigan Avenue, Saginaw.

Observations are offered at the annual meeting of the state MDPAC organization by Orlen J. Johnson, M.D., Bay City, a past president of the Michigan State Medical Society. Leaders of the organization met recently to plan an ambitious calendar of activities for 1966.

International Meeting Coming to WSU '68

Headquartered in England, the Society for the Study of Human Biology will meet outside Great Britain for the first time in 1968 when it will hold a joint convention with the American Association of Physical Anthropologists at Wayne State University, April 23-26, 1968. Chairman of the local organizing committee is Gabriel W. Lasker, M.D., Professor of Anatomy. The convention will be an adjunct to the Wayne State University centennial celebration.

Preceding the meetings will be a series of intensive courses in modern methods of study in human biology, taught, in part, by the foreign professors visiting WSU for the convention.

Sees Bypass Pump Soon

New materials which appear to be harmless to blood should make it possible for a partial artificial heart to function in man "for months or even years," Michael DeBakey, M.D., declared here at a program sponsored by the Galens Society.

The Houston heart surgeon is confident that "before the end of this year comes to pass" the bypass pump will be in use in a man. The pump has already kept animals alive indefinitely.

Dr. DeBakey spoke February 9 to an estimated 1,000 people at the University of Michigan Medical School.

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An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

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(meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its anti-anxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of pre-existing symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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Talk to OR's

Two physicians spoke at the 1966 Spring Conference for Operating Room Nurses recently in Detroit. The event was sponsored by the Michigan Nurses Association.

Charles Townley, M.D., Port Huron, discussed "Initial Appraisal and Treatment of the Injured Patient and Recent Advances in Orthopedic Surgery as an Aid to Nursing."

C. Paul Hodgkinson, M.D., Detroit, told about "Nursing Responsibilities—Radiation and Isotope Treatment and Implantation."

U-M PG Courses

The Department of Postgraduate Medicine of the University of Michigan reports the following courses for April, 1966:

Blood Coagulation Assay Techniques—April 4-8
Pulmonary Diseases—April 11-13
Otorhinolaryngology Conference—April 14-16
Ophthalmology Conference—April 18-20
Endocrinology & Metabolism—April 18-22
Recent Advances in Therapeutics—April 25-29

WSU PG Offerings

Wayne State University lists many continuing medical education courses for the spring.

Detailed information may be obtained from the WSU School of Medicine Registrar, 1400 Chrysler Freeway, Detroit 48207. The Spring Schedule includes:

Four courses in Occupational and Environmental Health.

Seven courses in Psychiatry.

One course in Radiation Therapy.

Seven courses in Neurology.

One course in Neurosurgery.

Two in Physiology and Pharmacology.

Two in Radiology.

Four in Surgery.

Detroit to Host '66 MAP Congress

The 7th Annual Congress of the Professions, sponsored by the Michigan Association of the Professions will be held in Detroit, Saturday and Sunday, Ma 14-15, 1966, with the new Pontchartrain Hotel a headquarters.

"The World of the Professional" is the theme fo the Congress. World-famous speakers are being invited to bring news of importance to the individua professional man.

A "National Breakfast" Saturday morning, May 14 will feature reports of what various state association of the professions are doing. The morning Annua Business Meeting will be followed by a "Top of the World Luncheon."

Discussions about the professions in their political, economic and scientific worlds will occupy the afternoon sessions. On Saturday evening, an "Outer Space Fantasy" dinner dance will be held in the beautiful Cabaret La Boheme atop the Pontchartrain.

On Sunday morning, May 15, all faiths will have an opportunity to learn about the "Religious World of the Professions."

The meeting is open to all members of the professions represented in MAP. These now include: architecture, certified public accounting, dentistry, education, engineering, law, medicine, pharmacy and veterinary medicine.

Sinai Lectures

Interested physicians are invited to hear Jules Masserman, M.D., co-chairman, Department of Psychiatry, Northwestern University, on April 26 and 27 at Sinai Hospital, Detroit. These Visiting Chief Day Lectures of the Sinai Hospital Department of Psychiatry offers Doctor Masserman on "Sex and the Singular Psychiatrist" at 8:30 p.m., April 26, and "Experimental Neurosis" at 10:30 a.m., April 27.

Emphysema has become a "health menace of major magnitude" according to Claire F. Ryder, M.D., in the U. S. Public Health Service's Division of Chronic Diseases. Deaths from emphysema-bronchitis quadrupled between 1952 and 1962. This disease complex is the fastest growing cause of death in this country.

"Medicine in Our Changing World"
Theme for MSMS Annual Session, Grand Rapids,
September 27-28-29-30

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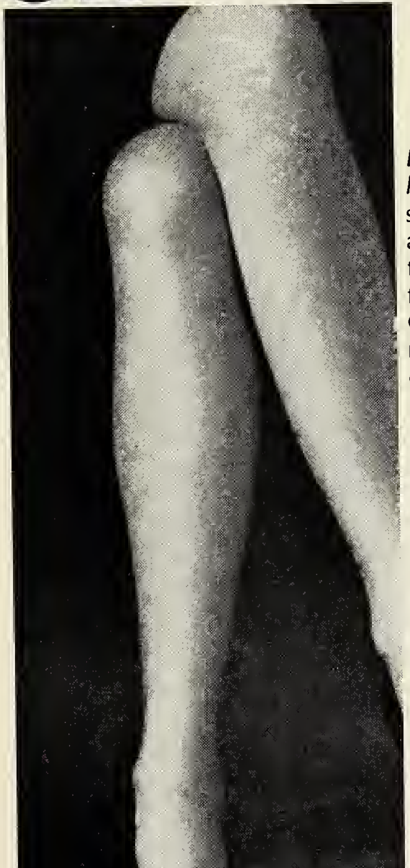
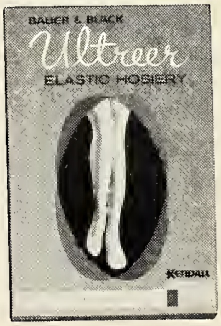


Elastic Stockings so sheer they look like support hose. Both Ultreer and support hose are sheer, shapely, cool and comfortable. But that's where the similarities end. New Ultreer fits firmly and evenly over the entire leg. Gives true therapeutic compression necessary to relieve varicose veins and other leg disorders. They provide the therapy you prescribe. The fashion and economy she demands.
Ultreer stockings have a new low price. So low, she can afford two pairs of Ultreer instead of one pair of regular elastic stockings. There'll be no disagreements there. Ultreer stockings are as comforting to her purse as they are to her legs. New Ultreer are the elastic stockings doctors and women can agree on.



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roviding combined anorexigenic-tranquilizing action, ADEX SEQUELS Capsules help your nonshrinking nts to establish new patterns of eating less. The am- amine component suppresses the appetite, while the robamate helps allay nervousness and tension. And for patients, the *sustained* release of the active ingredients ides convenient one-capsule-a-day dosage.

de Effects commonly associated with either compo- are possible but, to the extent these are dose-related, should normally be mild and infrequent, since the dosage of each component on the usual one-capsule- regimen is quite low. Also, the sedating effect of robamate and the stimulating effect of d-amphetamine te tend, to some extent, to cancel each other out. Ad- e effects not peculiar to either component have not reported. Side effects associated with d-amphetamine te include: insomnia, excitability, increased motor ity, confusion, anxiety, aggressiveness, increased li- , hallucinations, rebound fatigue, depression, dry th, anorexia, nausea, vomiting, diarrhea and increased iovascular reactivity. Effects associated with meprobamate include: skin rash, nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema, fever and transient leukopenia; also, very rarely, fainting spells, angioneurotic edema, bronchial spasm, hypotensive crisis, anuria, stomatitis, proctitis and anaphylaxis. Other serious effects have occurred after concomitant administration of meprobamate and other drugs. Massive overdosage may produce grave effects.

Precautions: BAMADEX SEQUELS should be given only under close supervision to patients hypersensitive to sympathomimetic drugs, with cardiovascular or coronary disease or who are severely hypertensive; to emotionally unstable persons and to epileptics. Patients should be cautioned not to drink alcoholic beverages while on the drug, and not to drive vehicles if they become drowsy. In all patients kept on the drug for long periods, the drug should be withdrawn gradually to avoid possible serious reactions.

Contraindications: Hyperexcitability, agitated prepsychotic states and a history of previous reactions to meprobamate.

Bamadex® Sequels®

d-amphetamine sulfate (15 mg.) and meprobamate (300 mg.) Sustained Release Capsules

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6655

State Committee Named on Education For Health Care

The Michigan State Board of Education has appointed a Committee on Education for Health Care to study Michigan's medical and paramedical educational needs over the next 20 years.

In addition to Supreme Court Justice Otis M. Smith, Flint, who was named chairman earlier, members of the committee include Melvin A. Glasser, Detroit; State Health Commissioner Albert E. Heustis, M.D., Lansing; Emory W. Morris, M.D., Battle Creek; Carl A. Moyer, M.D., Houghton; Mrs. Gilbert Pingree, Detroit; and the Rt. Rev. Ralph Richards, Saginaw. Several more members will be appointed in the near future.

The group will give specific attention to the need for new medical schools. Their report will be incorporated in the statewide plan for the development of higher education in Michigan.

Leon Fill, M.D., a member of the State Board of Education, continues as chairman of the State Board's subcommittee on medical education with Edwin L. Novak, and Donald M. D. Thurber, two other members.

Webber Hospital To Open in '70

A new adult medical and surgical teaching hospital will be constructed in the Detroit Medical Center and will honor the name of a family long associated with good hospital care. The new 425-bed teaching hospital, to be called "Webber Medical Center," is planned for completion in 1970.

The Webber Medical Center Hospital will be built between the Grace and Harper Hospitals on Brush Street. Both the Grace and Harper buildings will connect with the new hospital and it, in turn, will be physically connected with a new, central Out-Patient Building which will be constructed later by Wayne State University. The new unit, which will be built by Harper Hospital, will be used as the primary outlet for teaching adult general medicine and surgery in the Medical Center.

It was Richard Webber who first invited the presidents of other hospitals involved in the Detroit Medical Center area to sit down and talk about the whol concept back in 1955.

TB Seal Sale Up

The 1965 Christmas Seal campaign in Michiga continues to show an increased gain over 1964. Current contributions stand at $1,375,307 which is a increase of $119,718 over the same period at this tim last year.

Michigan surpassed its 1964 campaign total o $1,301,000 on January 17, and was cited by the National Tuberculosis Association as the second stat tuberculosis association to go over the top in campaign contributions.

MSU Gets $160,800 To Evaluate New Medical Education

A $160,800 grant from the Commonwealth Fun will be used by Michigan State University's Colleg of Human Medicine to study the effectiveness of th new approaches to medical education it will begi next fall.

The grant will support three years of a continuing extensive research and evaluation study that will follow students through medical school, clinical trainin and into their careers.

The program to be examined evolved out of studie supported by a 1961 Commonwealth Fund grant o $167,000. These studies indicated that the traditiona four years of undergraduate work and the first tw years of traditional medical education form a logica sequence. Accordingly, MSU views its program as a six-year unit.

The first students will be admitted this fall.

Funds for Kidney Research

A total of $76,357 has been awarded by the Michigan Kidney Foundation for study of kidney diseases and the efficiency of the artificial kidney. The funds will support work at Wayne State University, Henry Ford Hospital, the University of Michigan Children's Hospital of Michigan.

The grants were recommended by the Kidney Foundation's 23-man Scientific Advisory Board of physicians and physiologists, headed by Ruben Meyer, M.D.

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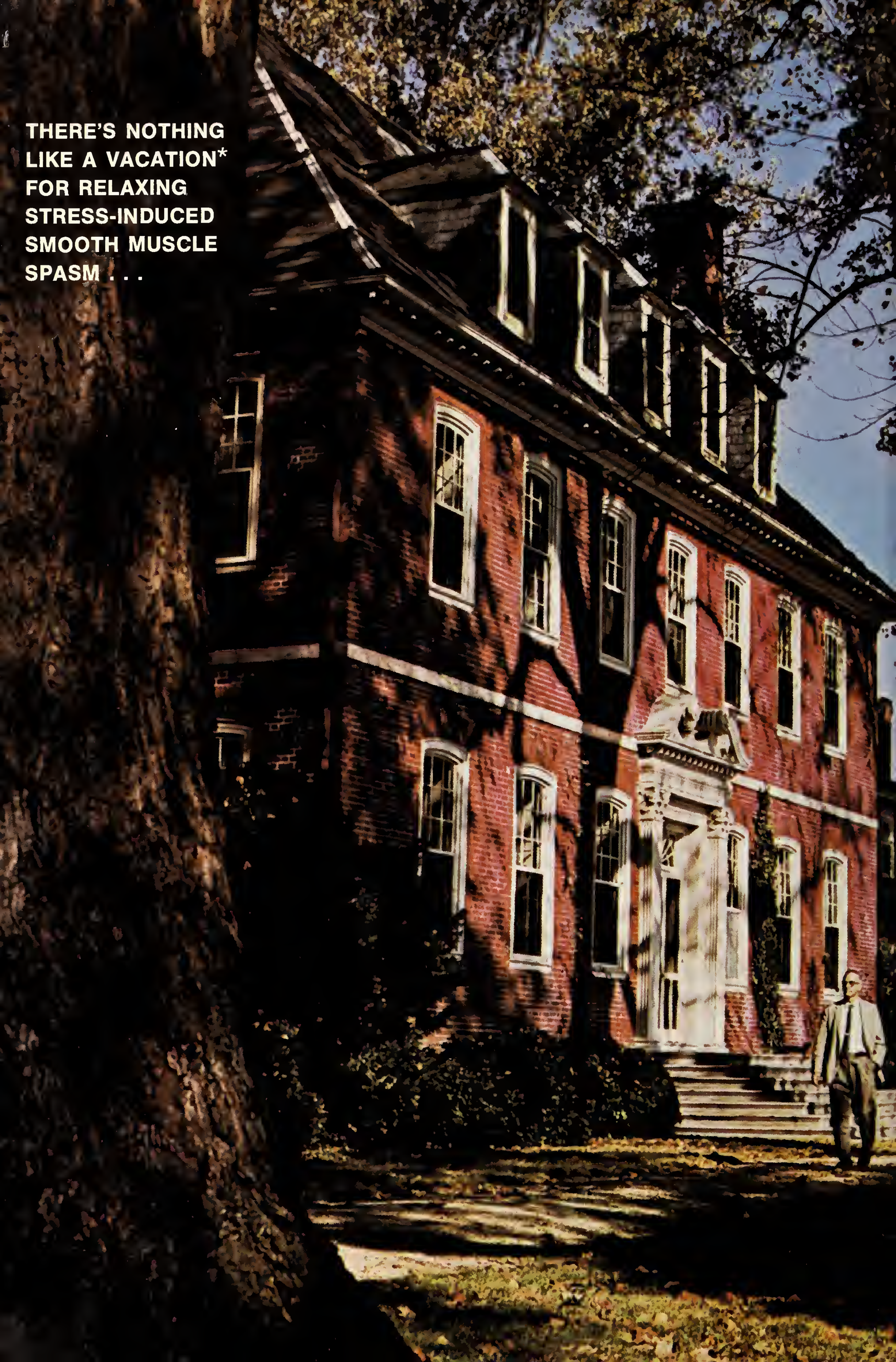
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FOR RELAXING
STRESS-INDUCED
SMOOTH MUSCLE
SPASM . . .

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DONNATAL®

ere's nothing quite like a vacation to ease the pressures of e modern, "workingday" world. And for the patient who can't t away from it all, there's nothing quite like Donnatal to relax ress-induced smooth muscle spasm. For 31 years it has been e antispasmodic-sedative most often prescribed for relieving nctional disturbances of tone and motility of the gastrointesal tract.

lladonna alkaloids in optimally balanced ratio

Donnatal, natural belladonna alkaloids are rationally balanced a specific, fixed ratio that provides "the greatest efficacy with e smallest possible dose."[1] They avoid the clinical uncertains of the variable tincture and extract of belladonna, and are nsidered superior in range of action to atropine alone.[2] rthermore, they are generally recognized as being more effece than the synthetics for relieving visceral spasm.

enobarbital for sedation

ars of clinical use have established phenobarbital as one of e most efficient and highly regarded sedatives. In fact, for neral sedation it is the drug of choice.[3] In Donnatal, phenorbital potentiates the spasmolytic effects of the belladonna kaloids, lessening emotional tensions and checking the neuronic impulses that trigger GI disorders.

ore than 24 indications in PDR

nnatal has withstood the test of time to become the classic dative-antispasmodic because of its unsurpassed effectivess, safety, economy, uniformity of composition, and dosage nvenience. Its widespread acceptance and usage by the prossion can also be attributed to its versatility in treating disders characterized by smooth muscle spasm. There are more an two dozen distinct and separate indications for Donnatal ted in the current PDR.

IN EACH TABLET, CAPSULE, OR (5 cc.) OF ELIXIR

hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide . . .	0.0065 mg.
phenobarbital	(¼ gr.) 16.2 mg.

(warning: may be habit forming)

IN EACH EXTENTAB

hyoscyamine sulfate	0.3111 mg.
atropine sulfate	0.0582 mg.
hyoscine hydrobromide . . .	0.0195 mg.
phenobarbital	(¾ gr.) 48.6 mg.

(warning: may be habit forming)

BRIEF SUMMARY: Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma, or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease, or a hypersensitivity to any of the ingredients.

REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

A. H. ROBINS COMPANY, INC., RICHMOND, VA.

A·H·ROBINS

Parke, Davis & Company Celebrates Its Centennial

Parke, Davis & Company, observing its Centennial this year, is today one of the world's largest manufacturers and distributors of pharmaceutical products.

It has plants, branch offices, depots in 30 U.S. and Canadian cities; 57 branches, subsidiaries and sales offices in international areas. Its headquarters and principal manufacturing, engineering and distribution offices are located along the Detroit River.

In addition, a 611-acre farm near Detroit is maintained for the development of biological products and virus vaccines; at Holland, Michigan, and Barcelona, Spain, the company operates chemical manufacturing plants; the principal research laboratories are located in Ann Arbor, Micigan, and in Detroit; and surgical dressings are manufactured at a plant in Greenwood, South Carolina.

This world-wide company now has approximately 65,000 stockholders with more than 14.5 million shares of common stock outstanding.

This firm had its beginning in the Detroit drug store of Samuel P. Duffield, M.D. It soon developed into a small manufacturing business and on October 26, 1866, founding date of the company, Hervey C. Parke joined forces with Dr. Duffield under the name of Duffield, Parke & Company. George S. Davis joined the enterprise a year later.

The scope of operations at the time is summed up in an advertisement in the Detroit City Directory which called attention to the company's "ether, sweet spirits of nitre, liquid ammonium, Hoffman's anodyne, etc., mercurial ointment, and blue pill mass, etc. For photographers and physicians our ether is unequaled in purity. List of prices furnished on application."

A small manufacturing laboratory was built in 1874 on the grounds of the present establishment, along the Detroit River. The following year, the business was incorporated in Michigan as Parke, Davis & Company with paid-in capital of $81,950, and five stockholders. The following year, with Mr. Parke as president and Mr. Davis as general manager, the company had net earnings of $4,139 . . . the first profits ever earned by the company. Parke-Davis' first cash dividend was declared in 1877. The company has continued regularly to pay dividends each year since.

Having invested heavily in research, the company in 1879 made pharmaceutical history with the announcement that a Parke-Davis preparation had been standardized through chemical assay. Earl skepticism of this development which assured uniformity in the potency of drugs was soon eliminated as other firms adopted standardization methods o their own.

Parke-Davis operations were extended abroad in 1897 with establishment of the first manufacturing facilities outside the U.S. at Walkerville, Ontario Canada. A British branch of Parke-Davis was established at London in 1891 and another in Bombay India, in 1899.

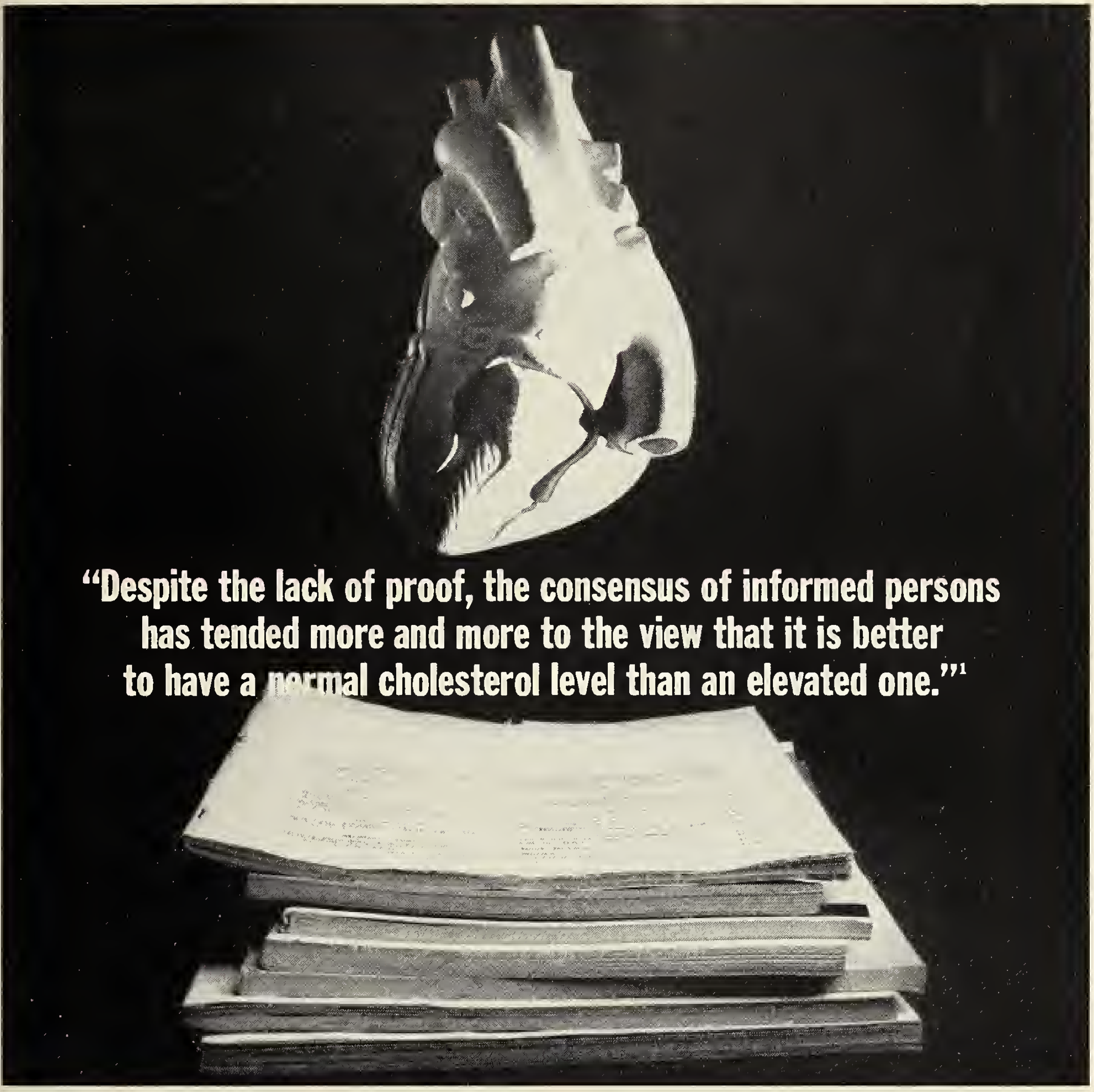
Advances in research and development of new products pushed the need for expansion. In 1894 Parke-Davis established in Detroit the first biologica laboratory in America and shortly thereafter obtained biological license No. 1 from the U. S. Government enabling it to produce a serum for diphtheria. On March 18, 1895, a Detroit physician administered a dose of Parke-Davis diphtheria antitoxin to an ailing company employe, the first commercially produced serum administered to anyone in the U. S.

Mr. Davis sold his Parke-Davis holdings and left the company in 1896. He died in 1930. Hervey Parke continued as president after Davis' retirement Then, in 1899, while on a California business trip he died, ending the era of Parke and Davis as active managers of their company.

Since the turn of the century, Parke-Davis contributions to the pharmaceutical and medical professions have been significant. The discovery of Adrenalin was the result of study of glandular and hormonal products. The company was a leader in vitamin research. It has developed, in the chemotherapeutic field, drugs for combatting syphilis, leprosy, epilepsy; the first antihistamine, Benedryl; and Chloromycetin, the first antibiotic successfully produced entirely by chemical processes.

Parke-Davis products now total about 500, and represent some of the most effective remedial agents used in medicine today. Few medicinal agents that existed when the company was first organized have survived.

Harry J. Loynd, the present chairman of the board. recently said, "Our company in the past 100 years has made significant contributions both in the development of new drugs and through the investment of our scientific know-how in the bank of knowledge about illness and health, all of which will aid in the better understanding of disease and its causes."


"Despite the lack of proof, the consensus of informed persons has tended more and more to the view that it is better to have a normal cholesterol level than an elevated one."[1]

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(ALUMINUM NICOTINATE)

- ☐ Reduces cholesterol by 15-30% in most patients[2]
- ☐ Matches nicotinic acid in effective reduction of elevated serum lipids—but with minimized tendency to cause flushing[3]
- ☐ Simpler, more practical than diet[1]

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NICALEX Prescribing Information: COMPOSITION: Each tablet contains: Aluminum Nicotinate 625 mg.—a complex consisting of (approx.): Aluminum Hydroxydinicotinate 450 mg. and Nicotinic Acid 155 mg. (Equivalent in activity to Nicotinic Acid 500 mg.) INDICATIONS: The primary indications for NICALEX (Aluminum Nicotinate) are to reduce the serum cholesterol and total lipid levels in hypercholesteremia and hyperlipemia. It may also be useful in reducing xanthomatous tissue cholesterol deposits. PRECAUTIONS AND WARNINGS: Patients with peptic ulcer, liver, or gallbladder disease should be observed closely while taking the medication. Diabetic patients may require adjustment of diet and insulin dosage in the event of decreased tolerance. Patients receiving anti-hypertensive drugs of the adrenal-blocking type should be watched for signs of postural hypotension. Occasional side effects of Nicotinic Acid in large dosage are decreased glucose tolerance (resembling diabetic-type curve) sometimes with glycosuria, temporary activation of peptic ulcer, transient jaundice, and metabolic disturbance of liver function without definite hepatic pathology. These side effects were found to be reversible upon discontinuing nicotinic acid therapy. Certain transitory skin changes have been observed with nicotinic acid therapy. These include: dryness of the skin and keratosis nigricans, particularly in axillae. SIDE EFFECTS: Administration of NICALEX (Aluminum Nicotinate) may produce temporary flushing and pruritus, also mild gastrointestinal distress, but these reactions are transient and apparently not serious. DOSAGE: The adult dose is 2 to 4 tablets t.i.d. with meals. HOW SUPPLIED: In bottles of 100 and 1000. CAUTION: Federal law prohibits dispensing without prescription. REFERENCES: 1. Parsons, W.B., Jr., Mayo Clin. Proc., 40:822, 1965. 2. Goldsmith, G.A., Amer. J. Dig. Dis., 9:651, 1964. 3. Boyle, E., Jr., J. Amer. Geriat. Soc., 10:822, 1962. U.S. Patent 2,970,082

Taking an ECG?

Complete the clinical picture
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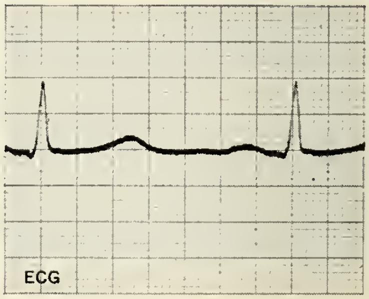
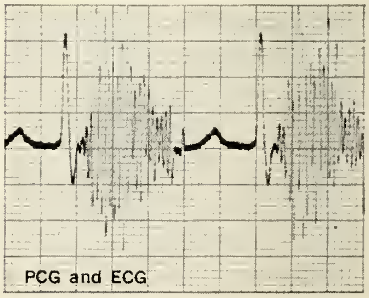
Increase your knowledge of cardiac condition with the valuable *additional* information provided by heart *sound* recordings. With this new Sanborn Heart Sound Amplifier clipped to the front of your 500 VISO* you can immediately obtain clear, sharply defined, graphic records — which identify the *location, intensity* and *duration* of the sounds and murmurs within the cardiac cycle. Even in the presence of complex arrythmias, marked tachycardias and other conditions which may complicate or prevent accurate auscultation by stethoscope alone, a definitive record of diagnostic quality can be obtained with this new instrument. Frequency cutoffs of 50, 100, 250 and 500 cps can be switch-selected to separate murmurs which might otherwise be masked by other heart sounds. As an electronic stethoscope, all sounds from 50 to 2000 cps can be heard at normal or amplified levels.

This precise Sanborn amplifier has convenient controls for recording the ECG, PCG, or ECG superimposed on the PCG . . . Cutoff Frequency . . . Audiophone Volume . . . and Sensitivity. Complete with contact microphone, cable and Audiophone (for use as an electronic stethoscope), Model 1506A is $450 f.o.b. Waltham, Mass. (continental U.S.). For more information, use the convenient coupon below. Sanborn Division, Hewlett-Packard Company, Waltham, Mass. 02154. In Europe, Hewlett-Packard S.A., 54 Route des Acacias, Geneva.

**or almost any other ECG with a 50 mm/sec. chart speed.*





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00 Work in New Jpjohn Labs

A new research building for the study of drugs and sease has changed the skyline of downtown Kalaazoo, but more importantly, it adds to Michigan's age as a center for medical and pharmaceutical rearch.

Built and equipped by The Upjohn Company at a st of $6.5 million, the building represents the most odern facilities available for chemical and biological search. In it and in other Upjohn research laboraries, scientists pursue their task of inventing and idying new drugs. At the same time, the work that es on will continue to add to medical knowledge ose aspects about human ills that are vastly imrtant to physicians and patients of Michigan and e world.

The new building, designed for the future, prodes for the most efficient use of work space. There a basic uniformity between chemical and biological boratories. This gives research a ready flexibility changing one type to another, simply by changing ork benches and other key, easily movable equipent.

The building contains 27 basic laboratories, a oup of laboratories for radioisotope studies, and 21 imal rooms. It has access to other parts of the search complex at several points. Occupied last ecember, the building provides space for about 100 ople: all of the Physical & Analytical Chemistry esearch unit, most of the Metabolic Diseases Rearch unit, and one section of the Pharmacology Rearch unit.

One of the most interesting instruments in the ucture is the radio-respirometer, which continusly records the amount and rate of respiratory gas change of test animals, an expression of total body etabolism. The instrument can also calculate the nount of radioactive CO_2 a test animal exhales as a result of the action of the animal's body on radioisotope-labeled test drugs.

Some of the research now being done in the new building can possibly have great effect on Michigan's physicians and their patients. For instance, studies of tissue inflammation may give physicians vital new weapons to combat rheumatoid arthritis and other inflammatory diseases. Other work may give those physicians a better understanding of obesity and the troubles it can cause. Still other work in fertility and nonfertility may lead to obviously desirable results.

"Coupled with other units of our Research Center," says Richard S. Schreiber, Ph.D., Vice President for Upjohn Research, "this fine, new research building will help Upjohn continue to set the pace in the fields for which it has become famous, for example, oral antidiabetes agents, oral contraceptives, antibiotics, and corticosteroids. Medicine in Michigan and medicine everywhere will benefit as a result."

This new building, and the research complex of which it is a part, houses but one portion of the chain of effort expended on the development of new medicinal agents. Preliminary studies of the effect of new drugs in man are carried out by a staff and volunteer subjects in a new building constructed by Upjohn at Southern Michigan Prison at Jackson. A recently-announced gifts of one million dollars by Upjohn to the University of Michigan for construction of the country's first clinical pharmacology facility at the University's Medical Center in Ann Arbor will provide a placement only to train physicians in the techniques of clinical pharmacology but also to carry out more advanced studies. But Upjohn's chemical and biological research which precedes any clinical evaluation starts here.

"Medicine/State" Book Available

"Medicine and the State."

This new book is available for any interested doctor to borrow from the MSMS Public Relations Library.

The book was written by two London physicians, M. J. Lynch and S. S. Raphael and published by Charles C Thomas, London publisher.

The book is a comprehensive study of the history, evolution and performance of national medical schemes as illustrated by those in Germany and Austria, the U.S.S.R., Britain, New Zealand, Australia, and Sweden. The book documents the efforts in each case by the medical profession to guard against the encroachment on the physician's freedom.

If you are interested in reading the book, just write to Public Relations Library, MSMS, 120 West Saginaw, East Lansing.

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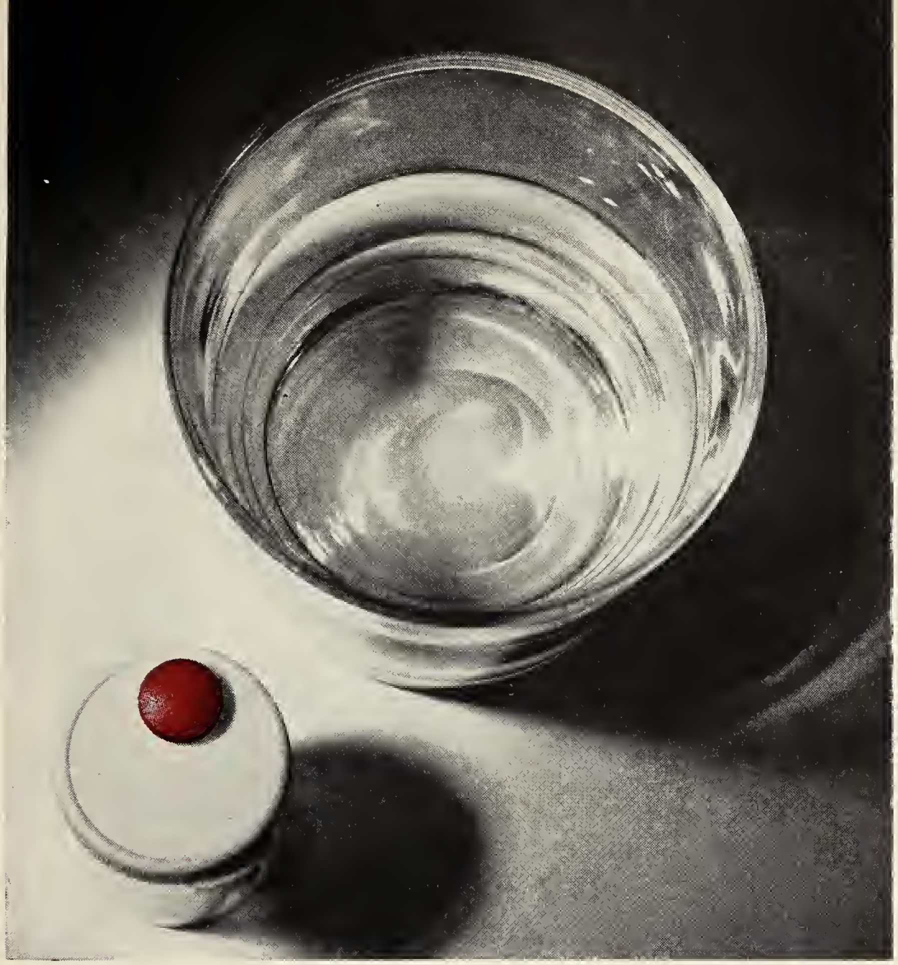
New 300mg tablet

ForAdults–2 tablets provide a full 24 hours of therap
...with all the extra benefits of DECLOMYCIN...lowe
mg intake per day...proven potency...1-2 days' "extra
activity to protect against relapse or secondary infectio

Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.
Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe manifestations. In a smaller proportion, photoallergic react have been reported. Patients should avoid direct exposure to light and discontinue drug at the first evidence of discomfort.
Precautions and Side Effects—Overgrowth of nonsusceptible or isms may occur. Constant observation is essential. If new in tions appear, appropriate measures should be taken. Us demethylchlortetracycline during tooth development (last trime of pregnancy, neonatal period and early childhood) may cause



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ation of the teeth (yellow-grey-brownish). This effect occurs
ly during long-term use but has also been observed in short
ment courses. In infants, increased intracranial pressure with
ng fontanels has been observed. All signs and symptoms have
ppeared rapidly upon cessation of treatment. Side reactions
de glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis
dermatitis. If adverse reaction or idiosyncrasy occurs, dis-
nue medication and institute appropriate therapy. Anaphylac-
reactions have been reported.

Contraindication—History of hypersensitivity to demethylchlortetracycline.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg of demethylchlortetracycline HCl.

Tablets: film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

DERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York Lederle

Urges Physicians Take TB Test

By Albert E. Heustis, M.D., M.P.H.
State Director of Public Health

It is a curious and rather sad truth, but all too often advances in the protection of health and the preservation of life are made only after—and because of—someone's sickness or death.

An obvious example is the dangerous stretch of highway which is redesigned only after a number of fatal accidents. Somehow, it requires dramatic, if not tragic, events to compel us to take corrective measures which were possible all along.

The recent outbreak of tuberculosis among pupils in a Garden City nursery school is a case in point.

* * *

Those of us in medicine and public health have known for years how important the tuberculin test is as a means of helping to prevent just such an occurrence. We have, for years, placed heavy emphasis on education to impress upon both physicians and patients alike the need for the tuberculin test right along with the basic immunizations and boosters.

Only last year, the tuberculin test was added to the so-called school checkpoint law, thus assuring that all entering school children would receive it at the time they started kindergarten.

But, by and large, the people remained unimpressed. And, to a lesser extent, it is fair to say that even physicians, by and large, remained unimpressed. Somehow the idea that tuberculosis is no longer a serious threat became accepted doctrine. It takes a Garden City episode to shake us out of our apathy, even if it is only a temporary emergence.

The result is a public clamor, a sudden and urgent demand for corrective action through the enactment of legislation. Currently there are several bills in the legislature which recognize the need for a state-wide uniform approach to the tuberculin-testing of persons who by the nature of their employment come into frequent and close contact with the public, such as teachers of nursery schools, workers in summer camps, day care institutions, etc.

Needless to say, none of these bills would require that physicians themselves be tuberculin tested at periodic intervals. And yet who, by the nature of their profession, comes into more frequent or closer contact with individuals than physicians? Now, we are not suggesting that such a requirement be enacted into law.

We remain convinced that the fundamental approach to public health must be educational not statutory. But we do favor legislation which would plug the gaps which still remain in terms of the tuberculin testing of nursery school teachers, barb beauticians, etc. And we believe that physicians, a profession, have a responsibility to lead the way protecting health and preventing disease.

* * *

Perhaps the greatest power that physicians ha is not to treat disease itself but to demonstrate precept. As a physician, it is a matter of great pri to me that today only about 20% of all physicia smoke cigarettes as compared with about 70% t years ago. This is demonstrating by precept and. am convinced, this alone is having and will have m impact upon the smoking habits of our people th all the legislation or lecturing in the world.

In the same way, I believe that when physicia themselves indicate by the force of example—by pr viding the periodic tuberculin test to themselves a to their patients, then this will ultimately have greater impact than any legislation possibly co have.

Early Planning!

Few members realize the amount of advance pla ning that goes into the MSMS annual scientific me ings . . . for example, a chairman has already be appointed for the 1966 Annual Session.

Oliver B. McGillicuddy, M.D., Lansing, immedia past-president of MSMS, has been appointed by T MSMS Council as General Chairman of Arran ments for the 1966 Session.

The 1966 meeting will be held September 25- at the Pantlind Hotel and Civic Auditorium in Gra Rapids.

Columbia University's Sidney Werner, M.D., cent clinical professor of medicine, presented the Merc Sharp and Dohme Lecture—"The Etiology of Hyperth roidism"—at the Fifth Annual Thyroid Workshop spo sored by the Wayne State University School of Medici and Detroit General Hospital. Pictured with him: Ale ander Walt, M.D., left, assistant dean at WSU School Medicine, and Nelson Taylor, M.D., general chairman this year's program. More than 250 physicians partic pated in the day-long meeting held at the Way County Medical Society headquarters.

Blueprint for dealing with tension due to stress — Prolixin — once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.

Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

SQUIBB FLUPHENAZINE HYDROCHLORIDE

THE SQUIBB TRANQUILIZER

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Survey Cites Importance of T

(Copies of the complete Roper address on "The Growing Importance of Television News" may be obtained from the Television Information Office, 666 Fifth Avenue, New York, N. Y. 10019.)

The growing importance of television news was discussed recently by Burns W. Roper, managing partner of Elmo Roper and Associates, New York City, at the American Bankers Association Public Relations Seminar.

Statistics from three similar surveys were cited by Mr. Roper. The surveys in 1959, 1961 and 1963, in part, revealed the following:

Question #1

"Where do you usually get most of your news about what's going on in the world today—from the newspapers or radio or television or magazines or talking to people or where?"

1959 REPLIES	%
Newspapers	57
Television	51
Radio	34
Magazines	8
Talking to people	4
Don't know	1

1963 REPLIES	%
Television	55
Newspapers	53
Radio	29
Magazines	6
People	4
Don't know	3

Question #2

"If you get conflicting or different reports of the same news story from radio, television, the magazines, and the newspapers, which of the four versions would you be most inclined to believe—the one on radio or television or magazines or newspapers?"

1959 REPLIES	%
Newspapers	32
Television	29

1961 REPLIES	%
Television	39
Newspapers	24

In the four-year period 1959-63, newspapers had dropped 4 per cent as a source of news, and television had climbed 4 per cent .

In the other survey on the believability question, television jumped 10 points with 39 per cent now calling it the most believable medium. Newspapers had dropped 8 per cent to 24 per cent.

Mr. Roper told the bankers, "A number of quite logical questions can be raised about our results. Perhaps 'believability,' for example, is connected with 'seeing it before oneself.' Yet 25 years earlier, radio, the completely invisible medium, had had the same edge over newspaper reports that television does now. I myself don't know all the reasons why our figures came out as they did, but I can suggest some not even raised by their critics. Perhaps, in their own minds, people were comparing the more standard quality of network television with the more varying quality of local newspapers. This could make a difference.

* * *

"OR, PERHAPS, THEY were affected by the newspapers' greater tendency to editorialize, for we have found that interpretation and bias are ve closely connected in the public's mind. Legitima expressions of editorial opinion are, for many peop tarred with the same brush as slanted reporting the news, and newspapers may suffer as a result. A this may be compounded because some newspape are not averse to letting their editorial comme 'wander' off the editorial page."

Mr. Roper also offered some comments about a brackets of the survey respondents.

Mr. Roper declared: "Suppose you could contin to have only one of the following—radio, televisio newspapers, or magazines—which one of the fo would you most want to keep? Of the group 50 a older, 40 per cent said television; of those from to 49, 44 per cent said television; of those 26 to 45 per cent said television, and of the youngest grou from 21 to 25 years old, the vote was 57 per cent favor of keeping television over the other three med

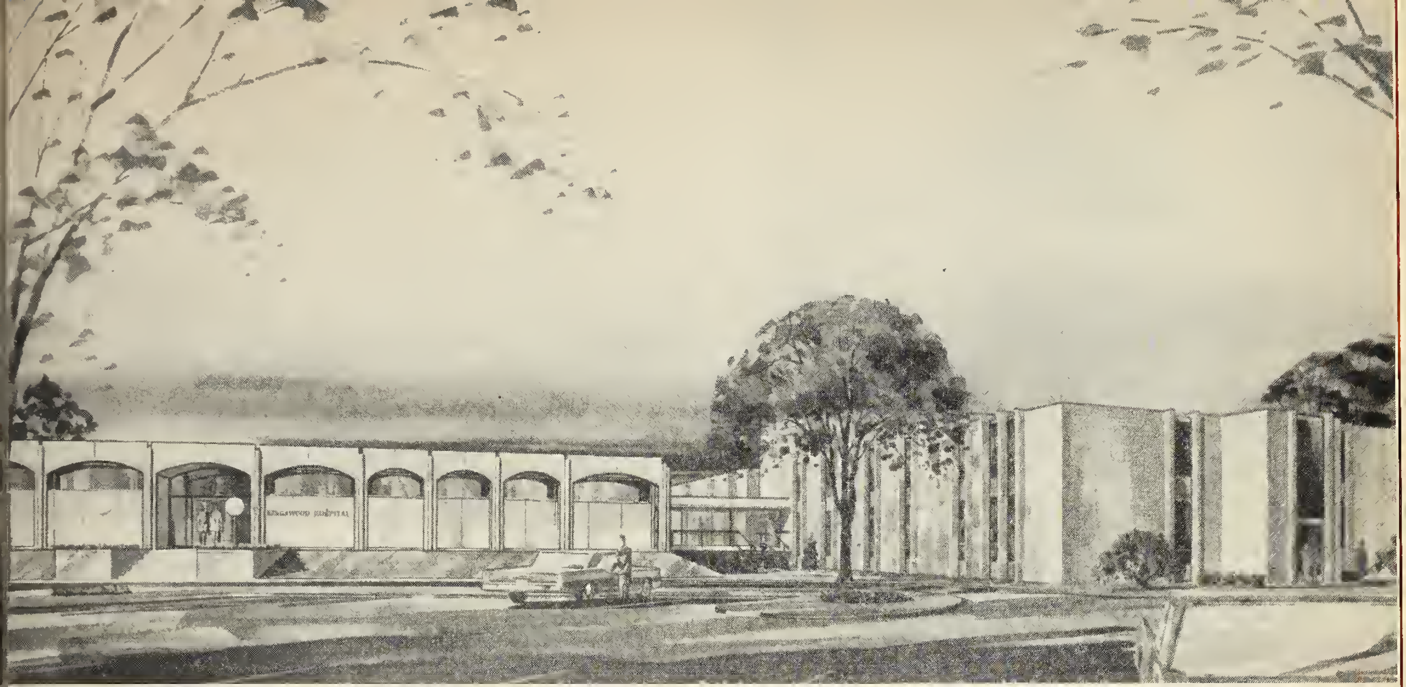
"It looks as though there is indeed a televis generation, which is increasingly coming into own."

Mr. Roper continued: "There is little I can a to what has been said and written over the last t decades about the increasing dominance of televisi viewing as a leisure time activity. People do look a lot of television, it has an impact on their attitu and activities; what that impact is, how much of is good, how much of it bad, has not yet been de nitely established. What these figures do show that there is increasing reliance on television, pa ticularly among those who have grown up with and that it is seen not merely as an entertainme medium but as a vehicle for serious news dissemin tion as well."

* * *

IN THIS ADDRESS to the bankers, Mr. Rop asked what the findings of the survey meant. I contended that: "One very clear implication is th serious public relations efforts will more and mo have to take television into consideration as an i portant part of the communications picture. Te vision is not just a passer of idle time or a tool to s things; I believe it will increasingly play a key r in the transmission of ideas."

In closing, Mr. Roper said: "We have reached point, not where television is about to become teacher instead of a plaything, but where televisi is increasingly turned to as the complete mediu capable of satisfying the needs for both fantasy a information."



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County Society Capsule Reports:

A public forum on "Blood Pressure and Stroke" was sponsored recently in Jackson by the **Jackson County Medical Society** and other allied organizations. Harold L. Oster, M.D., was the moderator, and the panel included Ross V. Taylor, M.D., Jackson; Frank Cullis, M.D., Detroit, and Richard C. Schneider, M.D., Ann Arbor.

The **Kent County Medical Society** recently presented a check for $100 to the Kent County Library for the purchase of nontechnical medical books. Last year, 21 books were purchased with the annual gift and are circulating from the 15 branch and community bookmobilestops.

The **Berrien County Medical Society** recently operated in immunization clinics conducted by Berrien County Health Department.

The **Calhoun County Medical Society Foundat** recently approved a program of scholarships, gra and aid to promote the training of nurses and m ical technicians in Calhoun County. Six differ programs were outlined. D. L. Finch, M.D., is pri-dent of the Foundation.

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ep. Harvey Wants hysicians to Speak heir Own Views

From Greensboro, N. C., Democrat

here is a feeling in some quarters that this na- 's doctors, whose principal organization is the erican Medical Association, take an "agin atti- e" toward just about every proposal for dealing n medical problems and issues.

his feeling was advanced when the AMA stoutly osed the medicare bill, which is now law. And it y be further advanced because of the AMA's op- ition to the establishment of a series of regional dical complexes to deal with certain of the major ases, as proposed by a presidential commission.

et this feeling, if it does exist on anything like a espread scale, is both wrong and dangerous. It is ed on suppositions without foundation in fact.

he AMA opposed medicare—just as it opposes the dical complex idea—for just one reason. That son is that the great bulk of its members were and convinced that these measures are not in the best rests of the ill or the medically needy. It believes, most strongly, that these interests will be dam- d, not advanced.

his brings up a very important point made by Representative Harvey of Michigan. Speaking to the president of the AMA, while testimony was being taken by a House committee on the regional complex proposal, he said: ". . . I can't help but think that certainly the easy way for the medical association and yourself would have been simply to have agreed with the President's Commission. . . . Certainly, we in this country . . . don't want our medical profession to be composed of yes men. I don't think we have obtained the finest medical profession in the world because you have been yes men but because of the reverse. They have always had the courage to come in and express their views. . . ."

It is the duty of the medical profession to oppose what it is convinced is wrong and to stand up for what it is convinced is right. And that is what it is doing.

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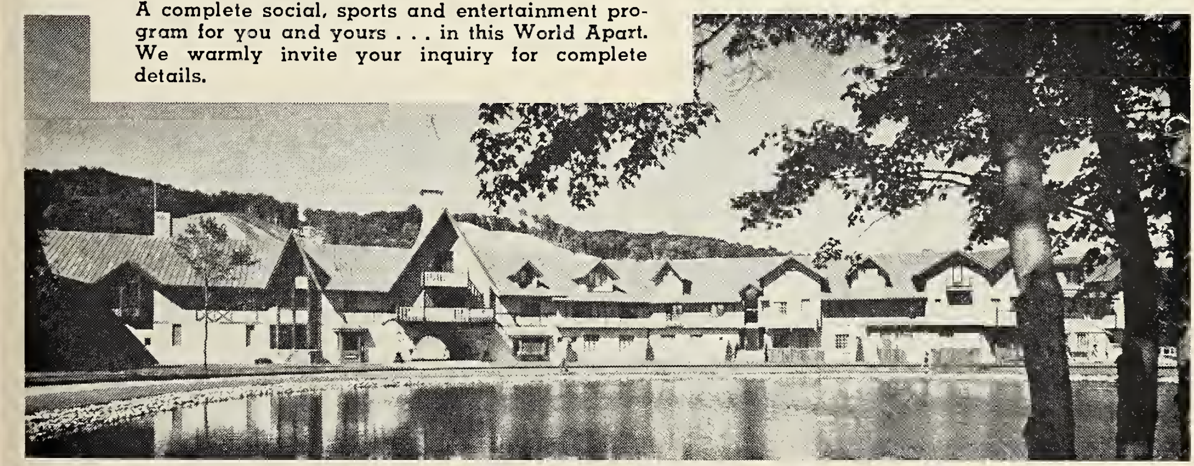

PERSONAL MENTION

Sanford M. Izner, M.D., Detroit,
is currently serving as president of the Michigan Society of Psychiatry and Neurology, and the Michigan District Branch of the American Psychiatric Association. He is a clinical assistant professor of psychiatry at Wayne State University

William A. Lange, M.D., Detroit,
was the last tenant to move out in February from the once fashionable Doctors Building on John R across from Harper Hospital. The city owns the old Doctor's Building in the Medical Center area.

C. S. Rogers, M.D., Bay City,
is chief of surgery on the S. S. Hope. He left Bay City in January and flew to Panama to board the mercy ship.

Harry Maisel, M.D., Detroit,
recently received a $500 award from the Probus Club for academic achievement. Doctor Maisel, an associate professor in the WSU Department of Anatomy, has conducted extensive research towards the understanding of cataracts.

Gerald E. Blanchard, M.D., Pontiac,
has been named director of Chevrolet-Saginaw Foundries. Dr. Blanchard, who since 1963 has been associate medical director of Pontiac Motor Division at Pontiac, succeeds Richard D. Mudd, M.D., who has retired after more than 37 years with General Motors.

Daniel Christian, M.D., Kalamazoo,
was lauded for his fine baritone voice as "Sharples "Madam Butterfly" presented by the Kalamazoo Symp Orchestra.

Richard E. Lininger, M.D., Benton, Harbor,
has been appointed medical examiner for Berrien Co He succeeds Russell Vastine, M.D., who retired in Jan

A. Hazen Price, M.D., Detroit,
has been appointed to a special committee of the Mich an Commission on Aging to evaluate projects submitted for federal funds.

J. W. Hoverter, M.D., Evart,
was lauded for his long years of service in a recent fea re article in the Grand Rapids Press. Doctor Hoverter ma ed his 90th birthday in February and reports that "althou don't have my shingle out anymore, I still treat the pat ts who have been coming to me for years."

J. Gregory Hamilton, M.D., Jackson,
was posthumously named the Jackson Jaycee "Young an of the Year" at the annual Jaycee DSA banquet. Do or Hamilton, active in community, medical and church aff s, died January 3.

Richard C. Bates, M.D., Lansing,
discussed "Alcoholism in Business and Industry" a Management Conference at Battle Creek recently. A ut 100 management and executive personnel from Michi n, Ohio and Indiana participated in the one-day confere ce which covered various topics.

Five Genesee County physicians
were honored recently by the Genesee County Med a Assistants Society at Flint, for service to the assista s' education program. Honored were Doctors Mark Le e, Robert H. Willard, Donald R. Canada, Gerald P. Berner d May Ann Guyon.

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rge H. Boyce, Jr., M.D., 700 Hamilton Avenue, ingsford, Michigan

S. Finch, M.D., 1400 Saunders Crescent, Ann rbor, Michigan

lter Grabowski, M.D., Box A., Kalamazoo State ospital, Kalamazoo, Michigan

ry E. Jennings, M.D., 766 W. Michigan Avenue, uite F, Jackson, Michigan

man M. Kale, M.D., 1840 Wealthy St. S.E., rand Rapids, Michigan 49506 *(Thoracic and eneral Surgery)*

W. E. Mldonado, M.D., Sparrow Hospital, Lansing, Michigan *(Pathology)*

Emilio Pena, M.D., 424 Monroe St., Dundee, Michigan *(Internal Medicine)*

Robert E. Reed, M.D., 707 Madison Pl., Ann Arbor, Michigan

Warren J. Roberts, M.D., 1020 Carpenter Avenue Iron Mountain, Michigan

James C. Sisson, M.D., 2318 N. Circle Dr., Ann Arbor, Michigan

Capt. Lee E. Taylor, M.C., 7481 A. Darnall St., El Paso, Texas *(General Practice)*

Henry Tellez, M.D., Wayne State University, Hospital Training Program, Detroit, Michigan

Fred L. Wedeking, M.D., Health Center, Western Michigan University, Kalamazoo, Michigan

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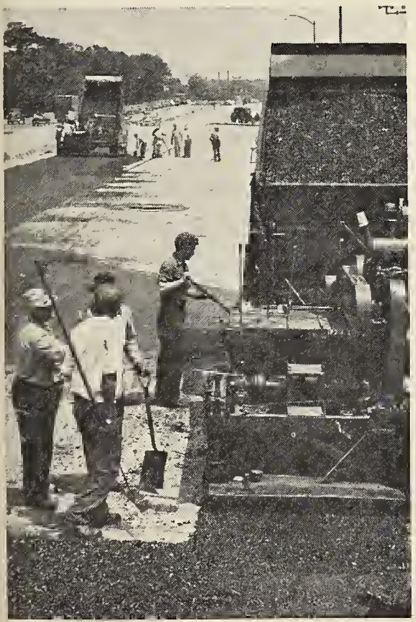

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A two-fold problem for the physician is . . . (1) to stay informed of what is available, and (2) to be well enough informed to assess new goods and ideas and then to select those which are appropriate to his practice.

A physician can get by, of course, without making any real attempt to "keep up." If he incorporates new drugs and new gadgetry into his practice occasionally—perhaps on the recommendations of a colleague or detail man—he will benefit by today's general rise in medical goods and knowledge.

American practitioners did not bring American medicine to its comman
position in the world with that kind of philosophy, however. American physi
do not want to settle for "getting by." The American physician is above ave
in intelligence. Generally, he makes great demands on himself and strives
perfection.

The new information comes from: colleagues, medical journals, medical
publications, continuing education courses, medical meetings and conventions,
detail men and some miscellaneous channels.

The convention is a favorite method with many of us. At the convention
physician has a chance to talk with detail men at commercial exhibits; he see
colleagues and exchanges views; he attends lectures, exhibits and seminars
together constitute a course in up-to-the-minute medical thinking.

May I now lead into an invitation that members mark their calendars for
great conventions:

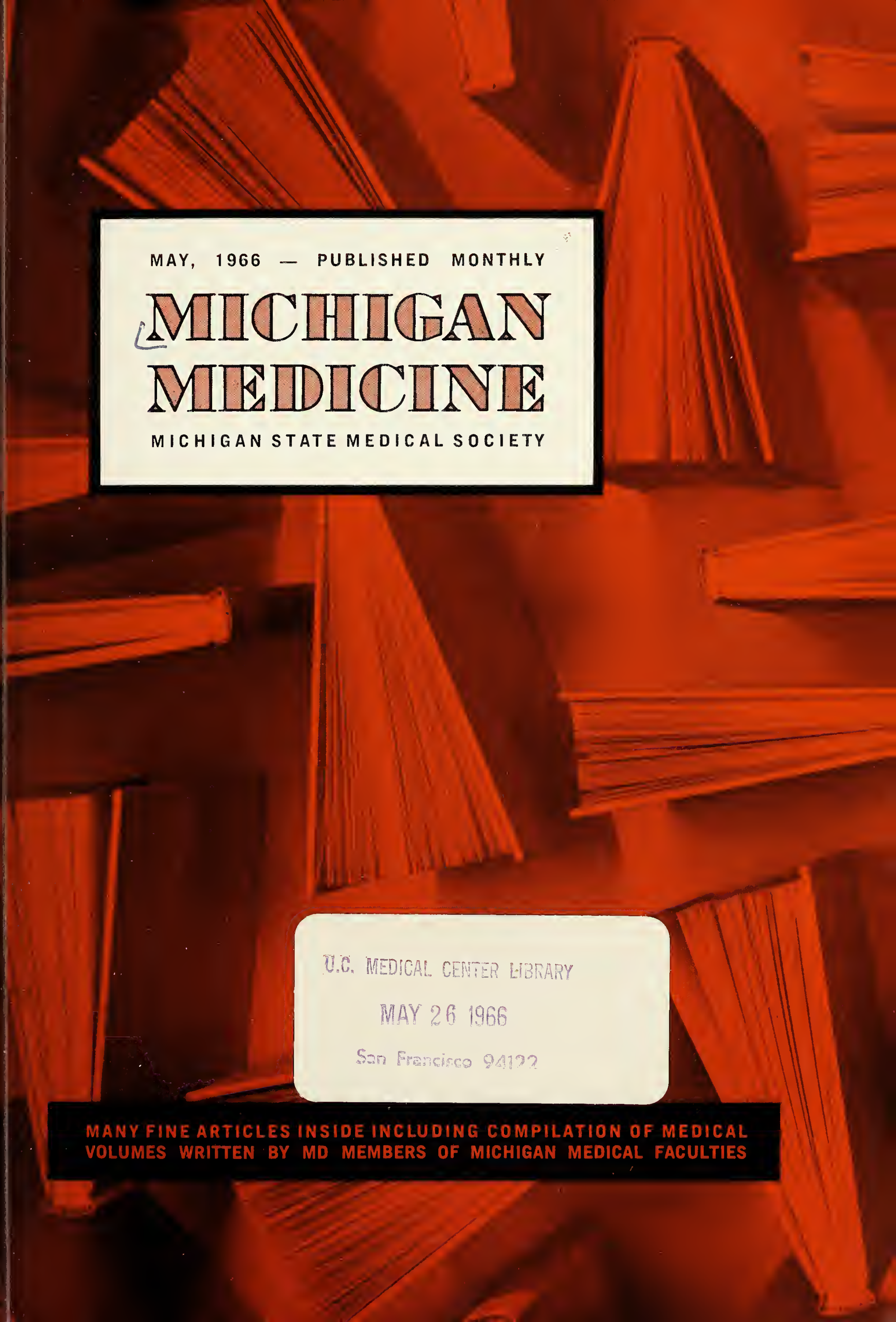
. . . **The 115th Annual Convention of the AMA in Chicago, June 26-30**
. . . **The 101st Annual Session of MSMS in Grand Rapids, September 27-28-29-30.**

Such annual meetings offer almost unlimited opportunities for absorbing
information and gaining new perspectives.

Our devotion to excellence makes it a must for us to participate in these
medical meetings if at all possible.

Luther R. Leader

MSMS President Leader, right, studies the program for the upcoming AMA meeting in Chicago with Wm. A. Hyland, M.D., MSMS Treasurer and Chairman of the MSMS Delegation to the AMA House of Delegates.



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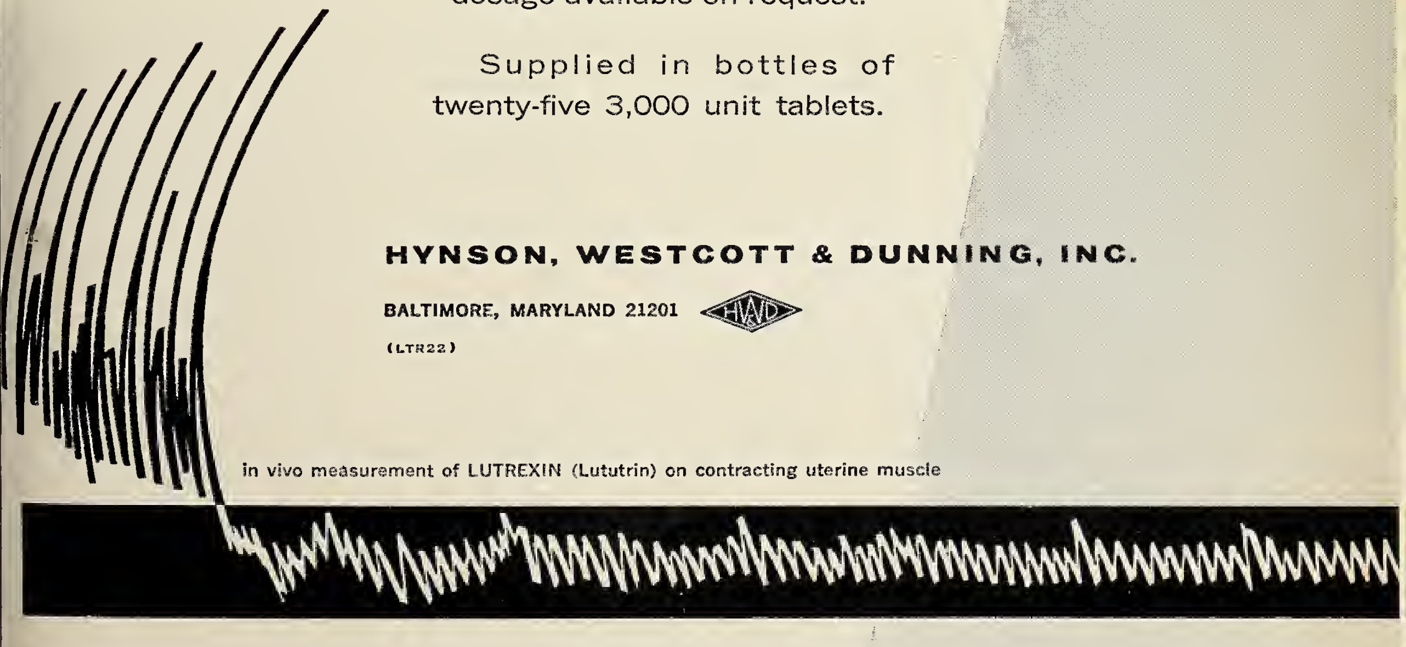

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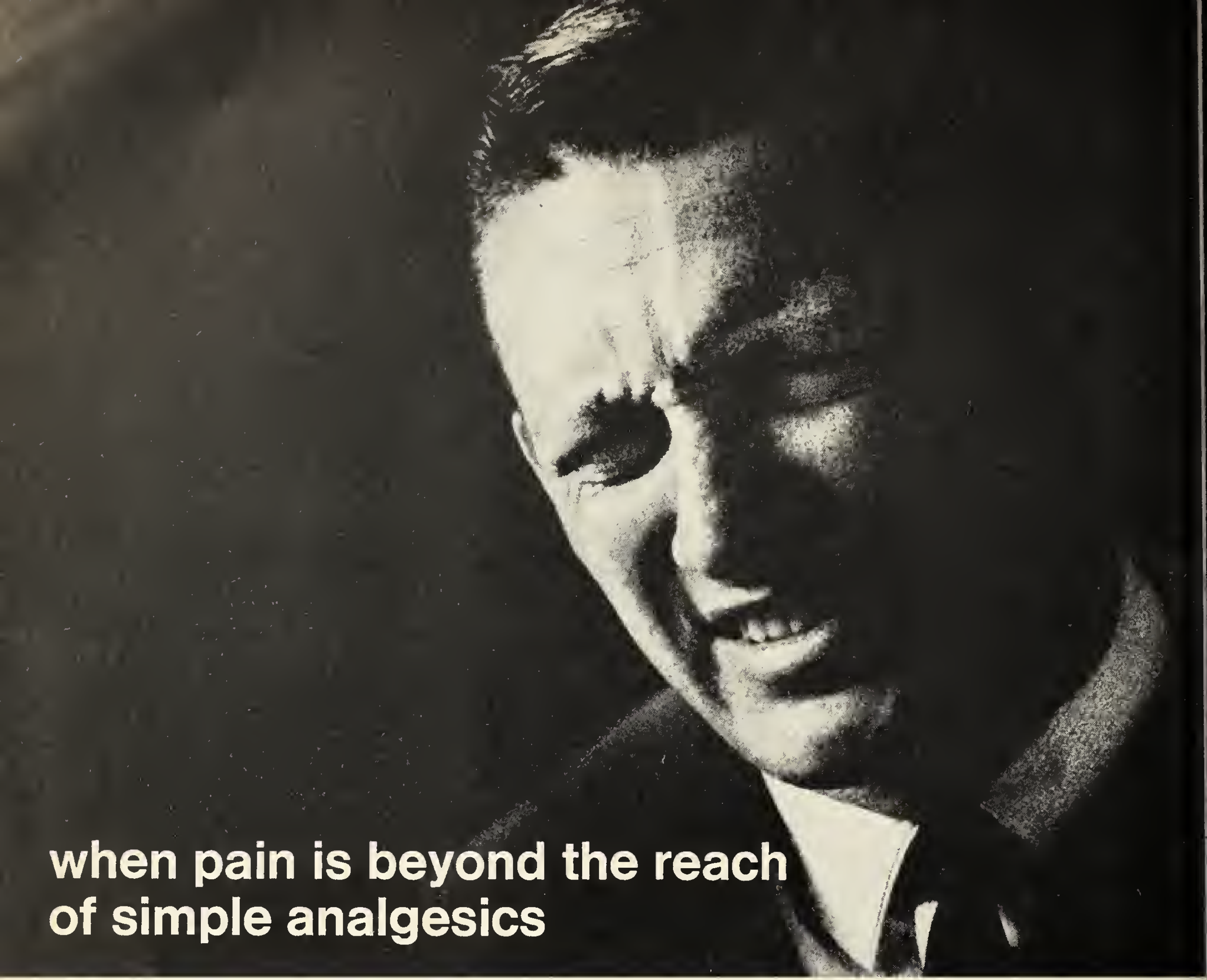

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1. Collective studies, Department of Medical Research, Winthrop Laboratories.

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MAY, 1966
VOLUME 65, NUMBER 5
PUBLISHED MONTHLY BY
MICHIGAN STATE MEDICAL SOCIETY

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ublished monthly, except two extra issues to be published in October and December, by the Michigan State Medical Society ts official journal at 2642 University Ave., Saint Paul, Minn. 55114. Second class postage paid at Saint Paul, Minnesota. rly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, 0 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exnges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East sing, Michigan 48824. © 1966 Michigan State Medical Society.

THE FORUM QUESTION THIS MONT

How can we impress people with the dangers of cigarette smoking?

Austin A. Aardema, M.D.
Muskegon

To impress people with the dangers of smoking, we must first impress the physicians who smoke. It is difficult to tell a healthy person that smoking is a potential danger to his life when he has seen and knows that many physicians ignore this advice. If our profession would show its concern through abstinance, the public might then follow our instructions and leadership.

Secondly, I try to emphasize other factors besides lung cancer. Many people feel that cancer can only occur "in the other fellow" and find it difficult to see themselves in the statistics. I emphasize the potential relationship between smoking and chronic bronchitis and emphysema and the effect on the cardiovascular system.

We must impress young people with the virtues of being an individualist and resisting the temptation to smoke "just to be one of the crowd."

Peter Kane, M.D.
Mt. Clemens

One of the ways to impress people with the dangers of cigarette smoking would be to have the AMA make a positive statement condemning smoking.

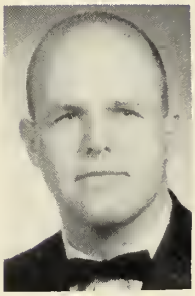
Michael J. Brennan, M.D.
Detroit

What can be done to educate the public regarding the dangers of cigarette smoking?

Professional medical societies, voluntary health agencies, and the health departments of local, state and federal governments together constitute a large

M. J. BRENNAN
M.D., Detroit

WILLIAM HAEC
M.D., Grand Rap



A. A. AARDEMA
M.D., Muskegon

JOHN R. CALDWE
M.D., Detroit

nucleus of informed persons possessed of major
nancial and personnel resources. Even when th
have acted individually, rather than in concert, th
have shown considerable ability in the utilization
mass communications methods.

The massive venereal disease education progra
mounted near the time of World War II by gover
mental health departments certainly achieved gr
success in improving the level of public understan
ing of these conditions.

The campaigns of the American Medical Assoc
tion against governmental financing of medical ca
succeeded in making the position of the Associati
clear to a great many.

The Polio Foundation achieved a truly extraor
nary public cognizance of and response against
rather uncommon, though very tragic, disease.

Concerted and sustained public education progra
generated in these agencies, expertly designed to
fectively utilize the mass media, are needed to redu
cigarette smoking. The ordinary means of pub
education through individual and group indoctrin
tion which these organizations employ have not be
able to educate the public sufficiently with regard
the dangers of cigarette smoking.

We readily sacrifice great sums to the search f

What Are Your Views?

Your opinions are invited for this new Forum feature in MICHIGAN MEDICINE. The question for the July issue will be "How can we reduce the number of non-emergent patients receiving care in hospital emergency rooms?"

Write down your suggestions in a letter and mail before May 25th to Michigan Medicine, 120 West Saginaw Street, East Lansing.

B. M. Harris, M.D.
Chairman, Publication Committee

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Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

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the causes of cancer. We have found a major predisposing cause of one kind of cancer. Yet virtually nothing has been done, compared to what can and should be done, to give free and responsible citizens the opportunity to protect themselves and their children from this tragic illness.

Advertisements which urge children and adults toward unhealthful habits are contrary to the public interest. Certainly they are more immoral and viciously deceptive than those which merely defraud men of money. If tobacco were a drug, it would long since have been off the market under current FDA law.

That advertisements which lead to the adoption and strengthening of habits widely injurious to public health and expensive to the state should be credited as normal business expenses, so that business revenues expended for them are not taxed, is a practice more to be expected in the world of Lewis Carroll or Kafka than in a supposedly reasonable society.

The present balance of forces must be reversed. Education regarding the hazards of cigarette smoking through these media must be strengthened and propaganda for cigarette smoking impeded. As a nation, we have placed compassionate humanisms and social justice at the basis of our political life. This problem, of what we should do now that each of us knows his son should never form the habit of cigarette smoking, is a severe test of our honor. It is also a test of the validity of American social and political organization. Can we, within a context of freedom, attain a right ordering of our lives when prudence calls for one course to protect human life and health, and the economic interest of one segment of the population calls for another?

Effective education, and not prohibitive law, is the appropriate means for attaining the reform we seek. It is fully compatible with our fundamental principles which recognize the right and obligation of each man to govern responsibly his own behavior. Means must be found to change the role of mass communications media from one of recruitment and encouragement of smokers to one of preventing adoption and urging moderation of this widespread habit.

William Haeck, M.D.

Grand Rapids

In spite of the fact that the American Medical Association has not taken a stand on the relationship of cigarette smoking and cancer of the lung until more research has been accomplished, I personally, and many physicians, I am sure, are convinced of the causal relationshsip between cigarette smoking and lung cancer. We may tell our patients of this relationship, and there now are warnings on packages of cigarettes that smoking cigarettes may be injurious to

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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

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Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.

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health. This appears to be unconvincing, because sales of cigarettes continue to increase.

I am personally convinced that I must use scare tactics. Recently I uncovered three cases of carcinoma of the lung in one month. All were in people who were or had been cigarette smokers. One case was inoperable. When I have a patient who is a cigarette smoker I tell him that I had three patients in one month who had cancer of the lung and that these people all had been cigarette smokers. This is the kind of scare tactic I refer to. Even then, I do not believe I am too effective.

To show you how ineffective I am, two of my grown sons are fairly heavy cigarette smokers. One of these is a physician.

Benjamin B. Stamell, M.D.

Southfield

Cigarette advertising carries the message that smoking is a socially desirable habit amongst the beautiful and the virile. The television viewer cannot escape the blandishments of the lovely or forceful characters that are puffing away.

To counteract this, the profession could draw a truer picture of smoking. The fact that it is a noxious, unsanitary addiction must be repeated as often a possible. Perhaps, this might register with som people.

It is my opinion, however, that until some publi agency can match the publicity and advertising tha the tobacco industry has available, few inroads wil be made into this problem.

John R. Caldwell, M.D.

Detroit

We can impress people with the dangers of cigarett smoking by telling them cigarettes are arterial poison which rot out arteries and lungs. Tell them that th people who produce cigarettes and their Madiso Avenue promoters take yacht trips around the worl while they, the ones who support by their purchas of cigarettes such profiteers, suffer from cancer o the lung and coronary artery disease.

One way to help patients to stop cigarette smoking is to have them chew small pieces of licorice ever time they have a craving for a cigarette. This satisfie the need to have something to do with one's hand and mouth when the craving arises. It also stain the teeth and fingers and leaves a bad taste in th mouth and, hence, satisfies all the requirements fo cigarette smoking without the angiotoxic effects o the nicotine. Licorice also kicks their adrenal gland a little bit and makes it easier for them to weathe the abstinence.

An additional aid which is justifiable if there i associated high serum cholesterol, is nicotinic acid i doses of up to 500 mg after meals. This will smell and taste like nicotine, but has a vasodilator effec characterized by flushing of the face which occur frequently in the early stages of use of the drug. Reduction in serum cholesterol levels occurs and any hepatotoxic effects which may occur in a minority of patients are transient and reversible when the drug is discontinued.

With this system of cliches, pep talks and drugs, I have been able to convert many of my patients to people who used to smoke cigarettes.

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DORSEY Season

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Duodenal mucosa with ulcer crater—Approx. 80× Magnification.

Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

partners in misery: common cold and duodenal ulcer*

a century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

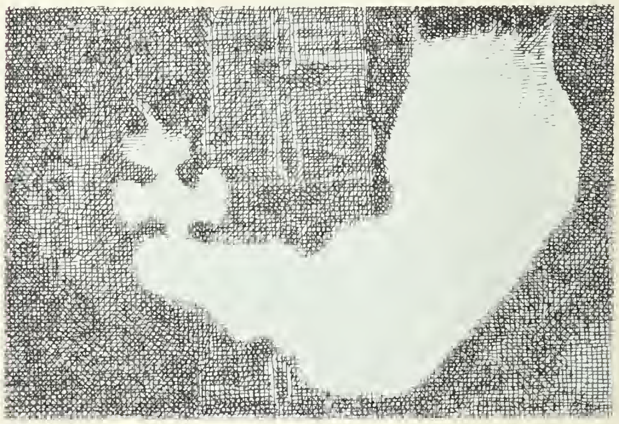
Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

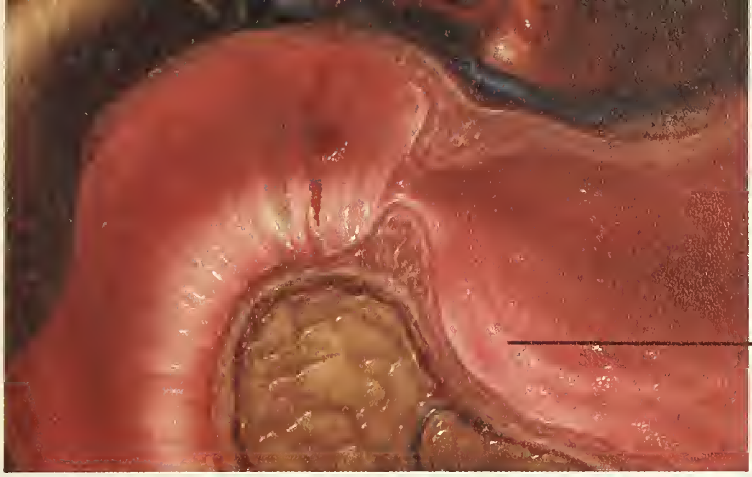
Case report A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.



Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.

pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

The care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced

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(Advertisement)

substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe enough in some instances to cause hematemesis and melena.[4] It has been suggested that interference with the protective mucous layer of the stomach allows this to happen. There is no evidence that hypersecretion occurs, but the taking of aspirin has been followed by exacerbation of ulcer symptoms and occasionally by gastrointestinal bleeding.[5] The ulcer patient with a cold should take salicylates with an antacid, or preferably other means of symptomatic relief should be found.

Caffeine has two actions on gastric secretion. One directly stimulates production of acid and the other potentiates the out-pouring of gastric juice as a response to other stimuli.[6] In high doses to animals, it has produced erosive gastritis and peptic ulceration. Caffeine-containing beverages are discouraged for the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings symptoms of nasal obstruction, loss of taste and smell and malaise similar to those caused by viral infection but due instead to allergens which at that time of year are principally tree pollens. Relief from these symptoms can be obtained, though not wisely, by the use of steroid medication. Unfortunately, chronic sufferers from these allergies have used this approach with varying degrees of success. Steroid hormones increase gastric secretion and delay the healing of experimental ulcers.[8,9] Clinically their administration has been associated with reactivation of healed duodenal ulcers, and with bleeding and perforation which were not always preceded by typical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided for other than serious medical problems and then only with adequate antacid coverage.

Summing up

It is immaterial by which pathways the malaise and lassitude, depression and irritability activate an ulcer, but it is the physician's responsibility to ensure that the medications he selects to relieve the symptoms of a cold do not further aggravate the ulcer.

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Arnold L. Brown, M.D., of Pontiac, is chairman of the 1966 MSMS House of Delegates Committee on Certificates of Commendation.

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The following have been presented "Certificates of Commendation" from the MSMS House of Delegates:

1962

Jerome W. Conn, M.D., Ann Arbor
G. D. Cummings, M.D., Lansing
Charles S. Kennedy, M.D., Detroit
Robert L. Novy, M.D., Detroit

1963

Forest D. Dodrill, M.D., Bloomfield Hills
Charles J. Jentgen, M.D., Detroit
(died in 1964)
John M. Sheldon, M.D., Ann Arbor
Homer H. Stryker, M.D., Kalamazoo

1964

Goldie B. Corneliuson, M.D., Lansing
John S. DeTar, M.D., Milan
Robert M. Heavenrich, M.D., Saginaw
Norman F. Miller, M.D., Ann Arbor
E. Gifford Upjohn, M.D., Kalamazoo
Orus R. Yoder, M.D., Ypsilanti

1965

Fred J. Hodges, M.D., Ann Aorbor
Traian Leucutia, M.D., Detroit
Remus J. Robinson, M.D., Detroit

Rated as "Excellent"

The publication "Michigan in Books," Vol. 8, No. , published by the Michigan State Library, carried he following comments about the MSMS Century f Service in Medicine by Wm. J. Stapleton, Jr., I.D., of Detroit:

"This excellent review of the Society touches upon he early years and provides greater detail for the ears 1929-1965. It complements and extends the formation published earlier by the Society in its wo-volume Medical History of Michigan."

Annual Session Sked Shapes Up

The Scientific Program for the 1966 Annual Session in Grand Rapids September 27-28-29-30 is fast taking shape.

The general timetable was announced in the April issue of MICHIGAN MEDICINE.

Now, Chairman Harry A. Towsley, M.D., Ann Arbor, reports that, to date, the following MSMS Sections and specialty groups have announced their meetings:

TUESDAY, SEPTEMBER 27: Reception-Dinner-Meeting of the MSMS Section on Orthopaedic Surgery and the Michigan Orthopaedic Society.

WEDNESDAY, SEPTEMBER 28: Luncheon-Meetings of the MSMS Sections on Internal Medicine, Dermatology, Plastic Surgery, Occupational Medicine, and Otolaryngology.

THURSDAY, SEPTEMBER 29: Morning meeting of the Michigan Diabetes Society; Luncheon-Meeting of the Section on Public Health and Preventative Medicine; late afternoon meeting of the MSMS Section on Ophthalmology and dinner-meeting of the Michigan Chapter of the American Academy of Pediatrics.

FRIDAY SEPTEMBER 30: Morning business meeting, luncheon, and afternoon slide seminar on "Gonadal Lesions"—sponsored by the MSMS Section on Pathology and the Michigan Society of Pathologists.

The 1966 Annual Session Program Committee includes Doctor Towsley, Chairman; W. C. Baum, M.D,. Grand Rapids; Alexander Blain, III, M.D., Detroit; W. A. Hyland, M.D., Grand Rapids; K. H. Johnson, M.D., Lansing; G. T. McKean, M.D., Detroit; F. P. Rhoades, M.D., Detroit; J. M. Sheldon, M.D., Ann Arbor; A. P. Thal, M.D., Detroit; and L. R. Leader, M.D., Detroit, ex officio.

CONSTANT GOALS

The professional association seeks to upgrade the quality of services rendered, improve the standards of practice, and further the interests of an entire group of professional personnel—locally, regionally, nationally and internationally.

—Quoted from
"Association Public Relations"

Sustained circulatory, respirat
and cerebral stimulation for t

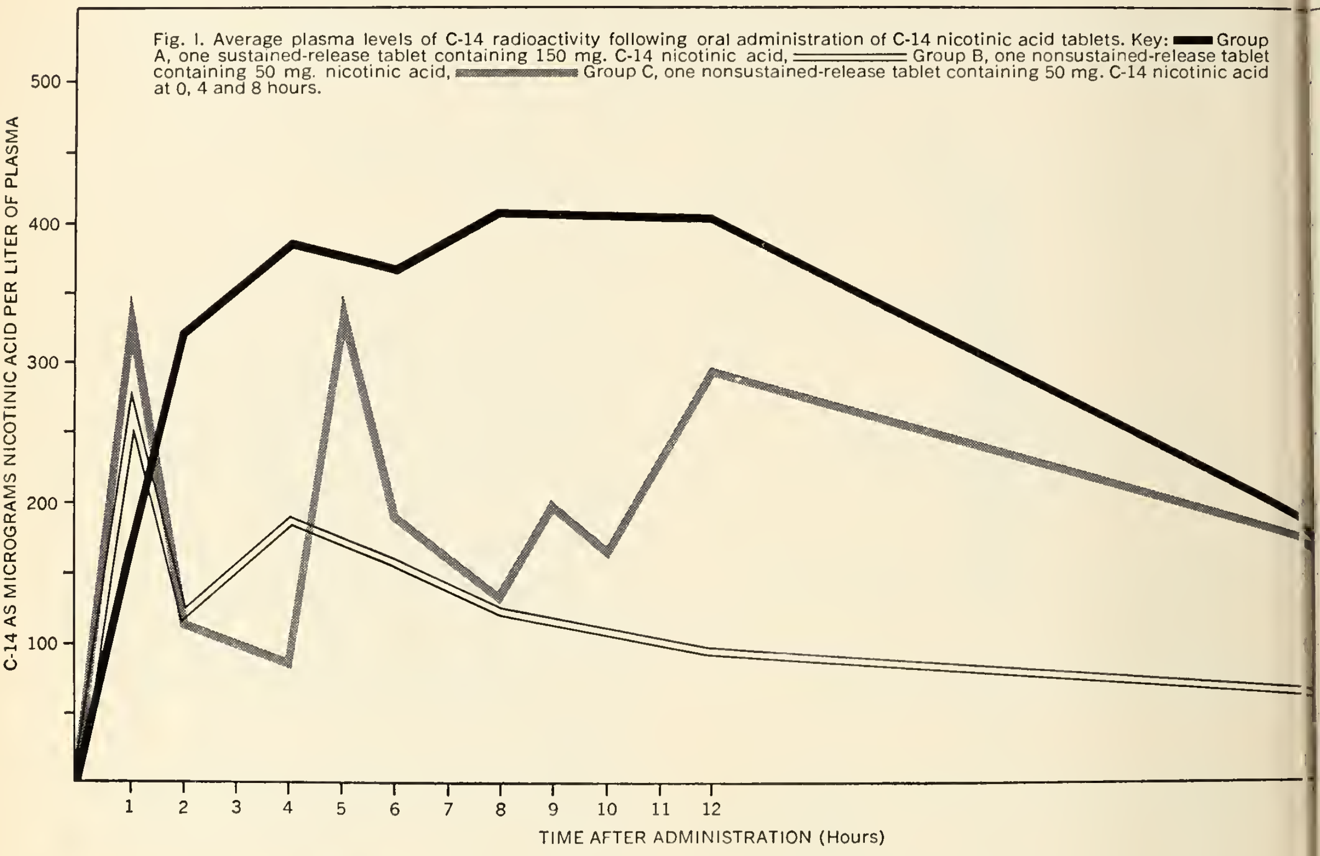


Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▒ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

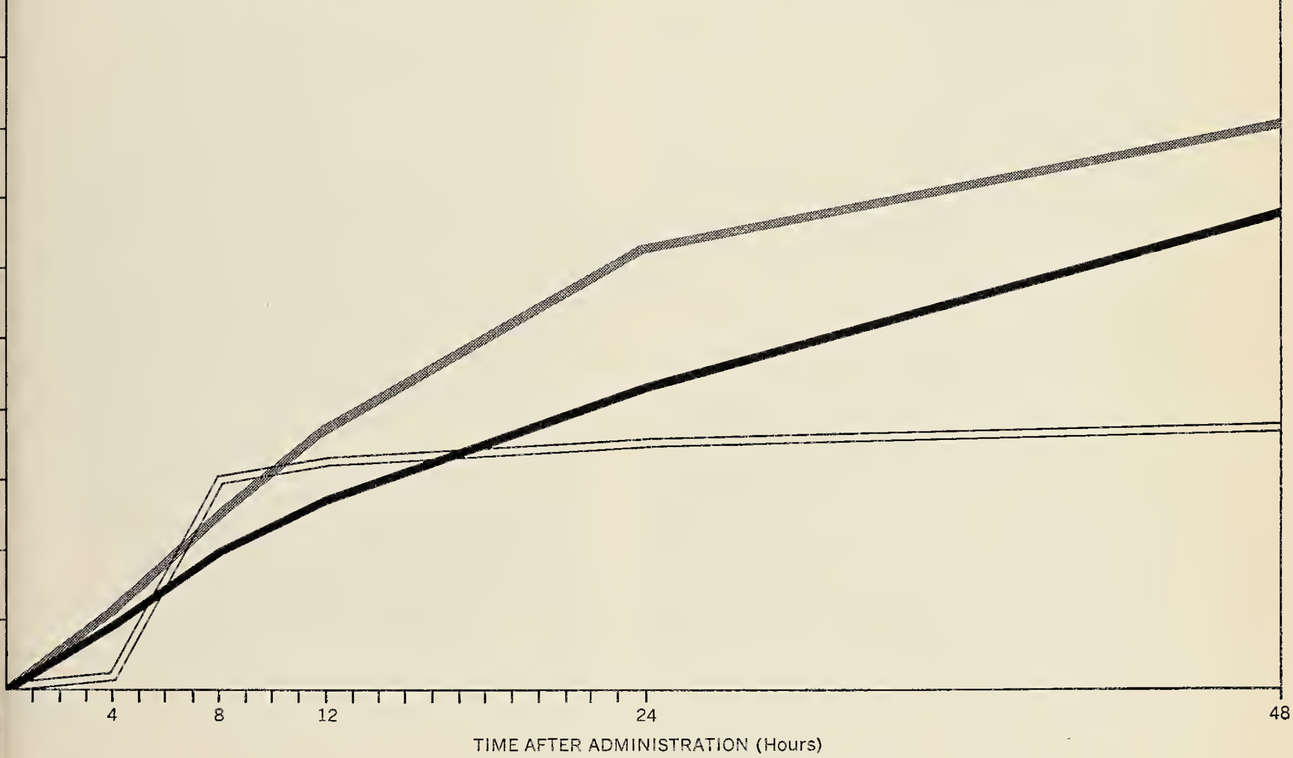
Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be c tinuous on a daily dose of only one Geroniazol TT t let every 12 hours.

The gradual release of nicotinic acid in Geronia TT will provide the well-known peripheral vasodila tion needed in patients with deficient circulation with a minimum amount (if any) of "flushing." Al cerebrovascular circulation is complemented by p tylenetetrazol, long-established as a cerebral and r piratory stimulant.

Geroniazol TT improves the typical, unfortuna signs of senile confusion. Patients become more al

ed and debilitated

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.



confused and moody. Personal care, memory, ional stability, social attention improve. Fatigue, ıy and irritability are reduced.

rescription for 100 tablets of Geroniazol TT will it your patients to enjoy the benefits of time-nged nicotinic acid/pentylenetetrazol therapy, economical price. Dosage is only one tablet every urs.

raindications: There are no known contraindica-

utions: Exercise caution when treating patients a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

"First with the Retro-Steroids"
PHILIPS ROXANE LABORATORIES
Division of Philips Roxane, Inc., Columbus, Ohio
A Subsidiary of Philips Electronics and
Pharmaceutical Industries Corp.

Geroniazol® TT
nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

MSMS to Nominate G. W. Slagle, M.D., For AMA Board of Trustees in Chicag

The MSMS delegation to the AMA has launched an aggressive campaign to elect George W. Slagle, M.D., Battle Creek, to the Board of Trustees of the American Medical Association. The election will be at the annual AMA convention in Chicago, June 26-30.

Wm. A. Hyland, M.D., MSMS Treasurer and Chairman of the MSMS delegation to the AMA, is directing the educational programs. Letters and a biographic brochure have been mailed to the AMA delegates and other influential doctors, and plans are taking shape for the convention activity.

The brochure, in part, describes Doctor Slagle's contributions to the AMA, MSMS, Calhoun County Medical Society and to his local community.

The following testimonials are offered:

Wm. A. Hyland, M.D., Chairman, Michigan Delegation to the AMA:

"A proven leader in vital AMA Council and Committee work since 1959, Doctor Slagle serves with distinction today in five areas of responsibility, i.e. service, practice, education, insurance and social security. A keen student of medical organizational processes and progress, George became a member of the Michigan Delegation to AMA House of Delegates in 1952 and has served continuously since that time. He has an excellent attendance record, has helped to determine AMA policies by contributing his time and talent to many reference committee deliberations."

Luther R. Leader, M.D., MSMS President:

"Vigorous in the work of the Michigan State Medical Society for more than 25 years, Doctor Slagle is a past-president of this 7,000-member society. His wise counsel was valued as a member
The MSMS Council for seven years. His colleagu
confidently and repeatedly have entrusted Georg
with many crucial roles of leadership within ou
Society and he has served with distinction as on
representative to state, community and governmenta
groups."

GEORGE W. SLAGLE, M.D.

Arnold Albright, M.D., President, Calhoun Count
Medical Society:

"Doctor Slagle is recognized as a prominent leade
in his profession and in the civic affairs of Battl
Creek and Calhoun County. More than 25 yea
ago, he was first elected a delegate to the Michiga
State Medical Society House of Delegates. Georg
is a past president of the Calhoun County Medica
Society. In community work, he is a former directo
of his local Chamber of Commerce and a concerne
member of the Congregational Church, youth-serving organizations, etc. George practices his contention that physicians must be vital parts of their communities."

Library Gift Honors MSMS Past President

A rare, 17th century book has been given to th
Michigan State University Library by Mr. and Mrs
Louis C. Plant of East Lansing in honor of the thre
medical doctors in their family who have been associated with MSU.

The book is an original Latin edition of Willian
Harvey's pioneer book in embryology, "Exercitation
de Generatione Animalium."

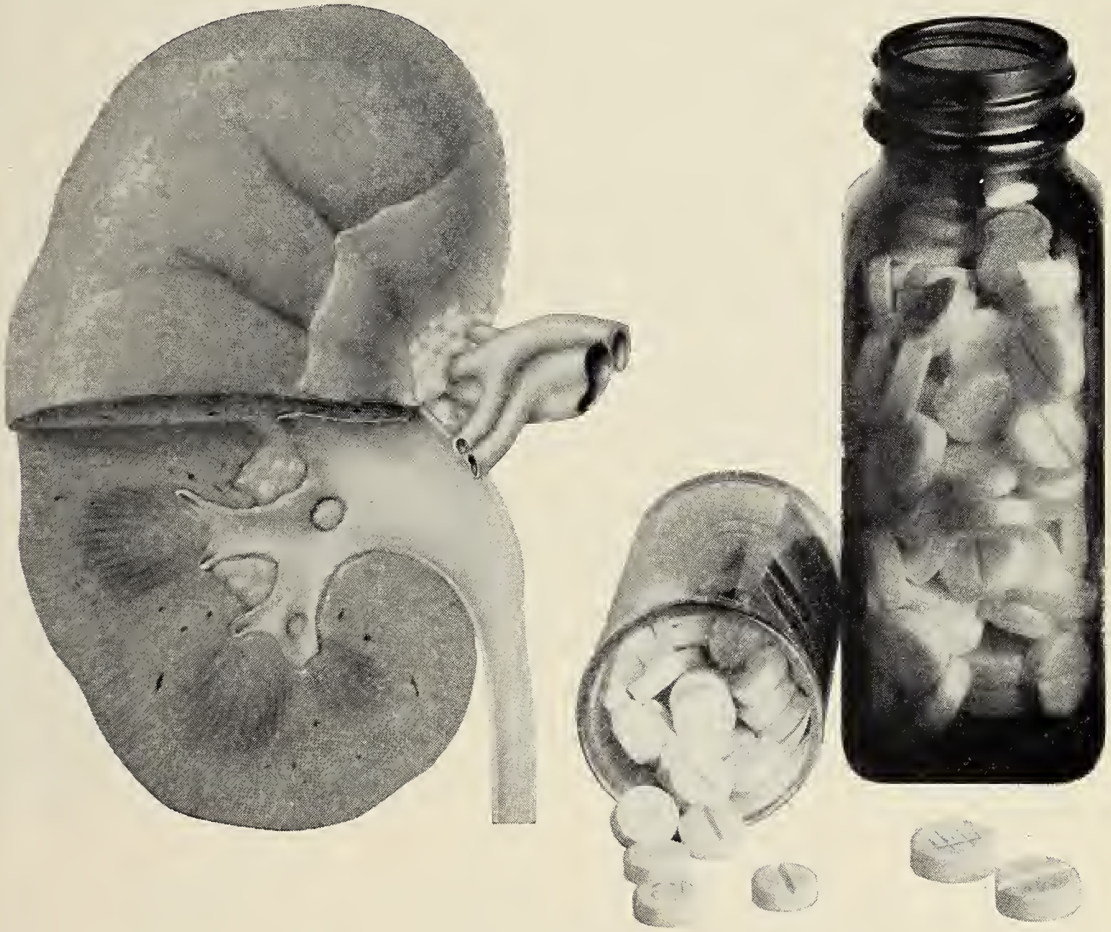
The three physicians honored by the gift of th
book to the library are:

—Mrs. Plant's grandfather, Dr. Robert C. Kedzie
professor of chemistry at MSU from 1863 to 1902
Dr. Kedzie served in the Legislature and on the firs
State Board of Health. He was president of the Michigan State Medical Society and a vice president o
the American Medical Association.

—The son of Mr. and Mrs. Plant, Robert Kedzie Plant, who received the bachelor of science degree a
MSU in 1929 and is now practicing obstetrics and gynecology in Seattle, Washington.

—Their grandson, Dr. Frank Kedzie Thorp, who received the B.S. at MSU in 1955 and is now chief resident in pediatrics at the University of Chicago. He will be an assistant professor there next year.

at Merck Sharp & Dohme...



understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

- Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.
- From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

MERCK SHARP & DOHME Division of Merck & Co., Inc., West Point, Pa.

where today's theory is tomorrow's therapy

Time to Think About Resolutions

Speaker of the MSMS House of Delegates, James J. Lightbody, M.D., suggests that it is not too early for county medical societies and individual members to think about resolutions for the September meeting.

When resolutions are submitted early, he points out, it is possible to give them full consideration and all delegates' benefit.

Following is the suggested form to be used:

**FORM FOR RESOLUTIONS
TO HOUSE OF DELEGATES**

Each resolution introduced in the House of Delegates shall be introduced by a Delegate. It shall be in writing and presented in triplicate to the Secretary. It shall be referred by the Speaker to the proper Reference Committee before action is taken thereon. (By-laws, Chapter 9, Section 13.)

Official printed resolution forms follow the below format:

Date ____________

Introduced by: ______________________________, **M.D.**

______________________________ **County Medical Society**

SUBJECT: ______________________________

Whereas, ______________________________, **and**

Whereas, ______________________________, **therefore be it**

RESOLVED: ______________________________

NOTE: Each Delegate is invited to send a copy of all resolutions to Speaker J. J. Lightbody, M.D., Box 152, East Lansing.

"Outstanding MD" Nominees Sought

Who will be "Michigan's Outstanding Physician of 1966"?

The House of Delegates Committee on Michigan's Outstanding Physician already has started its work. Conrad R. Lam, M.D., of Detroit, is the chairman.

Each county medical society has been invited to submit a nomination.

The 1964 House of Delegates took action to establish this annual recognition of Michigan's Outstanding Physician.

The resolution adopted by the Delegates in 1964 provided that this recognition be given to a member of the profession, "who is not necessarily a family physician, nor one advanced in years. . . ." The resolution resolved also "that consideration be given to the physician's civic accomplishments as well as his professional accomplishments."

The 1965 House of Delegates approved the recommendation of the selection committee and presented the first award to Franklin Troost, M.D., of Holt.

Task Force Studies Include Physicians

The Regional Task Forces on Community Healt Services, each composed of approximately 40 members who represent 16 segments of the community have been organized and have held from one to thre meetings each.

The groups have two broad tasks, according t Vlado A. Getting, M.D., Director of the Michiga Community Health Services Study, "to assess th community health needs of the region and the state and to recommend changes necessary for the efficien development of health services to meet these needs.'

Representatives of the medical profession on the si regional Task Forces are:

Region I (Upper Peninsula)

James H. Fyvie, M.D., Manistique, Vice Chairma of Executive Committee for Region I

Region II (Northern Michigan)

B. Elmore Henig, M.D., Grayling
William Kitti, M.D., Kalkaska

Region III (Southwestern Michigan)

David Millard, M.D., Paw Paw
Charles Ten Houten, M.D., Paw Paw

Region IV (Central Michigan)

Eleanor Skufis, M.D., Adrian

Region V (Southeastern Michigan)

Sidney Adler, M.D., Detroit

Region VI (Saginaw Valley-Eastern Michigan)

Orlen J. Johnson, M.D., Bay City, Chairman o Executive Committee for Region VI
Arthur Tuuri, M.D., Flint
Lionel L. Davis, M.D., Mt. Pleasant
Louis E. May, M.D., Howell
Richard D. Mudd, M.D., Saginaw

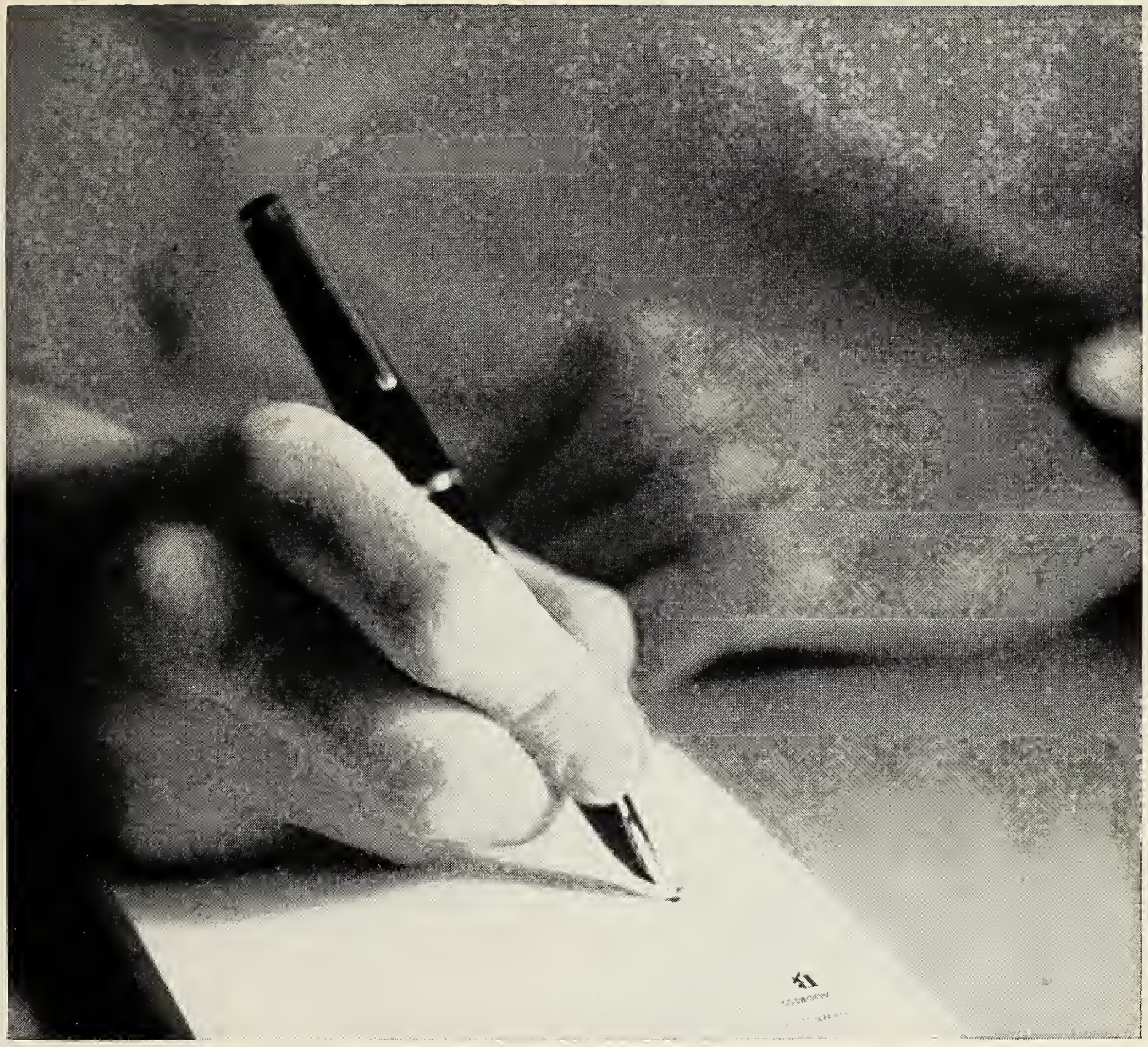
The Study is financed through grants from th W. K. Kellogg Foundation and the U. S. Public Health Service and administered by the University of Michigan. Sponsors of the Study are the Michigan Health Officers Association, the Michigan Department of Public Health, and the University o Michigan's School of Public Health.

For further information contact: Michigan Community Health Services Study, 122 South First Street Ann Arbor, Michigan.

Mark Your Calendar For Annual Sessions

The MSMS Council has approved the following dates and locations for upcoming Annual Sessions o the Michigan State Medical Society:

1966—Grand Rapids, Sept. 25-30
1967—Grand Rapids, Sept. 24-29
1968—Detroit, Sept. 22-27



One Signature

Insurance Protection for Doctors and Dentists

Ætna Life & Casualty's *Professional Package Policy* combines all the fundamental insurance protection you need against the risks inherent in your profession: (1) Professional liability necessary for alleged malpractice. (2) Office Premises Liability Insurance for claims arising from the operation of your office. (3) "All Risks" insurance for loss or damage to your equipment.

One conference . . . one signature is all an Ætna agent needs. Then he'll prescribe the protection that best suits you. And you'll appreciate his competence as an *insurance* professional. We call it *P.S. — Personal Service.*

Ætna
LIFE & CASUALTY

Abstract of MSMS Council Meeting

Meeting of March 16, 1966

MEASLES IMMUNIZATION

The Council urged renewed efforts in measles immunization and, recognizing the availability of a ne measles immunizing material, recommended that it be handled in the same manner as have other immunizin agents in the past.

REPORT OF MICHIGAN MEDICAL SERVICE

Executive Director John McCabe discussed the withdrawal of current Blue Cross contracts in favor o supplemental coverage; Blue Shield will permit those not signing up for Medicare under Part B to continu their M-75 contracts at least until Part B enrollment is reopened in 1967.

Also discussed was the Dependents' Medical Care Program fee schedule, for which MSMS is fiscal agent The Council directed that appropriate steps be taken to renegotiate this fee schedule.

NOMINATIONS TO MICHIGAN HOSPITAL SERVICE MEDICAL ADVISORY COMMITTEE

The Council renominated the current appointees, two to be elected by the MHS Board—Otto O. Beck M.D.; R. L. Novy, M.D.; and A. C. Stander, M.D.

NOMINATIONS TO DEPARTMENT OF SOCIAL SERVICES ADVISORY COMMITTEE

At the request of the Director of the State Department of Social Services, MSMS submitted the followin nominations for appointment to a medical advisory committee—Robert J. Mason, M.D., Birmingham; George W Slagle, M.D., Battle Creek; Harold J. Meier, M.D., Coldwater; Richard W. Pomeroy, M.D., Lansing; and Z Stephen Bohn, M.D., Detroit.

PARTICIPATION IN CORNELL AUTO CRASH INJURY RESEARCH PROGRAM

This program, approved by MSMS, is moving into a new area and The Council authorized a letter to aler physicians to the current six months' study to be conducted in the Upper Peninsula.

CONFERENCES ON FOOD AND DRUG SUPPLEMENTS

Upon recommendation of the Committee on Aging, The Council authorized cooperation with the Food an Drug Administration in conferences for senior citizens on the dangers of food and drug supplements, with th individual cooperation of members of the Committee on Aging.

COUNCIL SETS GUIDELINES FOR MEDICARE NEGOTIATIONS

Following is an extract from the report of the House of Delegates Committee to Determine Monetary Valu of Unit of Relative Value Scale. The Council approved each of the recommendations and referred Recommendation Four to the Constitution and Bylaws Committee.

"All indications are that there will be an expanding role of government in responsibility for medical care The governmental programs, of necessity, must soon offer only one scope of benefits and one standard o care, and ultimately this means only one fee schedule for providers of services. It, therefore, seems essential that any fee schedule be appropriate not only to the patient and responsible agency, but also to th physicians, and with the consideration that, in the near future, all physician income may be derived fro one such fee schedule. This means that the terms 'usual and customary fee,' or 'prevailing fee' necessitat a fee that would be fair to all concerned, and as if every physician's entire income were to be derived fro providing services under the single fee schedule. Such a schedule should therefore be one appropriate to th mean or average family income group in Michigan.

"The medical profession can no longer afford to subsidize a part of the population, since the profession wil no longer be able to regain this subsidy from any other segment of the population.

"With the foregoing facts and principles in mind, the Committee acted as follows:

"RECOMMENDATION ONE: That the Michigan State Medical Society adopt a policy that fee schedule(s for all governmental programs be based on the premise that such schedule(s) be fair, both to the respon

(Continued on Page 353)

Doctor,

Here is the Abbott anorectic program designed to meet the individual needs of your overweight patients.

ABBOTT

mood elevation

DESOXYN® Gradumet® (methamphetamine hydrochloride)

Smooth appetite control plus mood elevation.

The obese patient on a diet often has to battle depression as well as overweight. Desoxyn Gradumet helps the dieter in both battles by elevating the mood while it curbs the appetite. Thanks to the Gradumet, medication is smoothly released all-day from a single oral dose.

If she can't take plain amphetamine, put her on DESBUTAL® Gradumet

Calms anxieties; controls compulsive eating.

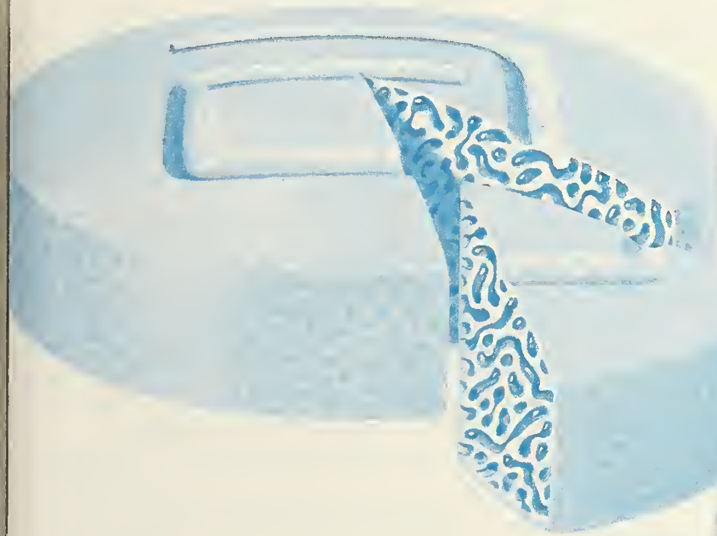
Desbutal Gradumet provides 2 drugs in 2 table sections, combined back to back to form a singl tablet. One section contains Desoxyn to curb the appetite and lift the mood; the other contain Nembutal® (pentobarbital) to calm the patient an counteract any excessive stimulation.

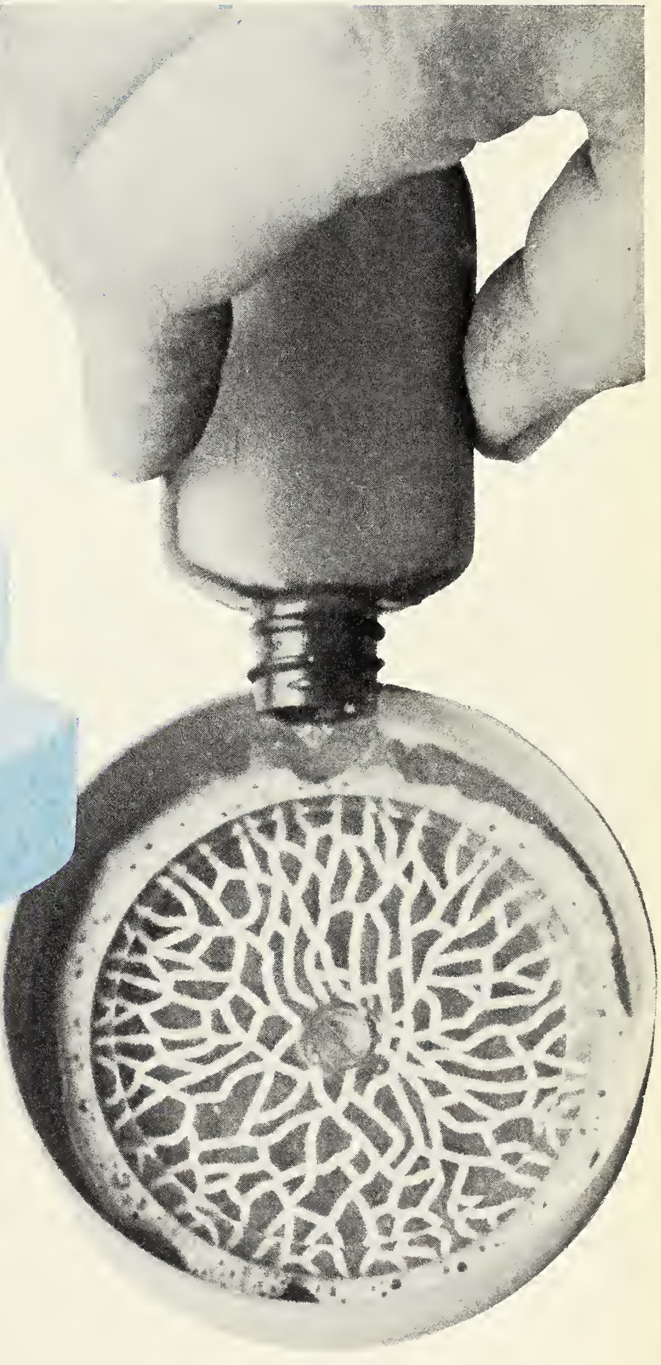
Both drugs are released in an effective dosag ratio throughout the day.

controlled release

Abbott
Anorectic
Program

Iot all long-release vehicles are
he same. Here is why the Gradumet
s different and what it means
or your overweight patients.





he release action is purely physical and relies on
nly one factor common to every patient: gastro-
ntestinal fluid. There is no dependence on enteric
oatings, enzymes, motility, or an "ideal" ion con-
entration in the gastrointestinal tract.
Your patients get a measured amount of medi-
ation, moment by moment, throughout the day.
They are not subjected to ups and downs of
rug release . . . or to erratic release from patient
o patient . . . or to erratic release in the same
atient from day to day.

hat's why the Gradumet provides
ontrolled-release as well as
ong release.

Perhaps you saw the Gradumet model demonstration which shows that the release is entirely physical. When fluid is added, the drug in the outer ends of the channels dissolves. As fluid penetrates deeper into the channels, there is a continuous release of medication. The rate of release is rigidly controlled by the size and number of channels.

choice of 5 strengths

Abbot
Anorecti
Progran

DESOXYN Gradumet

Methamphetamine Hydrochloride in Long-Release Dose Form

5 mg. 10 mg. 15 mg.

DESBUTAL 10 Gradumet

10 mg. Methamphetamine Hydrochloride,
60 mg. Pentobarbital Sodium

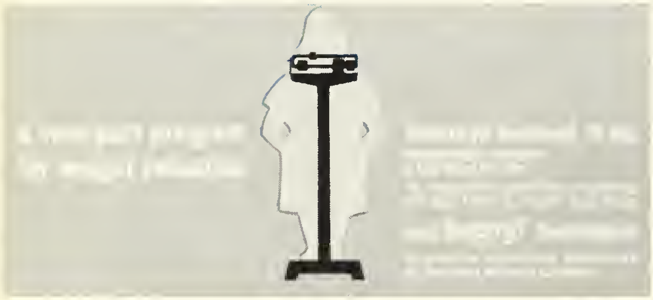
Front Side

DESBUTAL 15 Gradumet

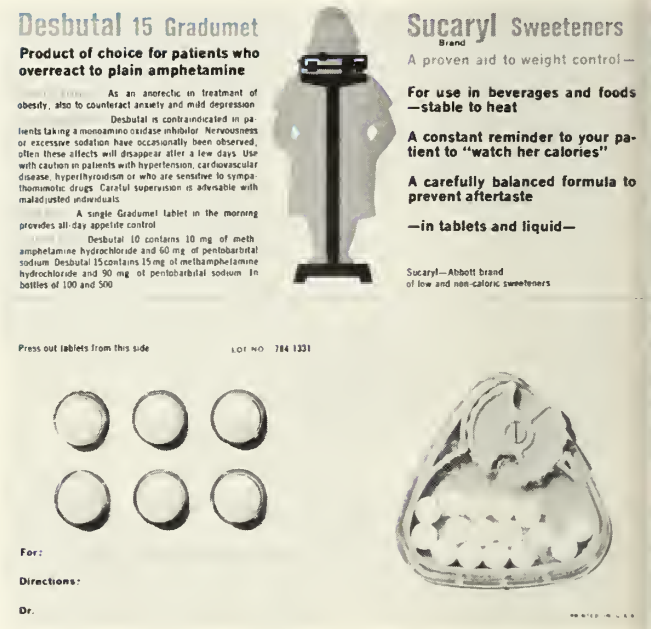
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium

Front Side

samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.



Desbutal 15 Gradumet

Product of choice for patients who overreact to plain amphetamine

As an anorectic in treatment of obesity, also to counteract anxiety and mild depression

Desbutal is contraindicated in patients taking a monoamino oxidase inhibitor Nervousness or excessive sodation have occasionally been observed, often these affects will disappear after a few days Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs Careful supervision is advisable with maladjusted individuals

A single Gradumet tablet in the morning provides all-day appetite control

Desbutal 10 contains 10 mg of methamphetamine hydrochloride and 60 mg of pentobarbital sodium Desbutal 15 contains 15 mg of methamphetamine hydrochloride and 90 mg of pentobarbital sodium In bottles of 100 and 500

Sucaryl Brand Sweeteners

A proven aid to weight control—

For use in beverages and foods —stable to heat

A constant reminder to your patient to "watch her calories"

A carefully balanced formula to prevent aftertaste

—in tablets and liquid—

Sucaryl—Abbott brand of low and non-caloric sweeteners

Press out tablets from this side LOT NO 784 1331

For:

Directions:

Dr.

economy

Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.

PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

ABBOTT

Gradumet—long-release dose form, Abbott: U.S. Pat. No. 2,987,445.
Sucaryl—Abbott brand of low and non-caloric sweeteners.

601060

UNCIL HIGHLIGHTS/continued

sible agency and to the physician provider of services, and based on the premise that the physician's entire income may become dependent on such a fee schedule(s); carried.

ECOMMENDATION TWO: That the monetary conversion factor for the 1965 RVS of the Michigan State Medical Society be established at $5 (five dollars) for this year; carried.

ECOMMENDATION THREE: That the monetary conversion factor for any approved RVS of the Michigan State Medical Society be subject to review and redetermination at annual intervals by the Michigan State Medical Society; carried.

ECOMMENDATION FOUR: That the 'House of Delegates Committee to Determine Monetary Value of Unit of Relative Value Scale' be made a *standing* committee of the House of Delegates, and with appointees selected as in the resolution approved by the MSMS House of Delegates in September, 1965; carried."

GOTIATIONS WITH MEDICARE INTERMEDIARY

The Council received a report of the Committee on Governmental Medical Care Programs with respect to preliminary negotiations with Michigan Medical Service, the Medicare fiscal intermediary, and authorized the mmittee to continue its negotiations with report to The Council at its next meeting.

LICY RE MEDICAL SURVEYS

The Council approved the policy that MSMS may survey, on proper request, the medical practice in a pital, and directed the Council's Committee on Hospital Relations to study and develop the mechanisms for king such surveys.

OPOSAL FOR MSMS INTER-SPECIALTY COMMITTEE

The Council authorized an ad hoc committee to study the feasibility and intent of a suggestion that The uncil appoint a 15-man committee to undertake the responsibility of (1) reviewing organizational problems h respect to scientific programs and (2) socio-economic and legislative problems that affect particular cialties. The ad hoc committee will present its recommendations to The Council at a future meeting.

AFF CHANGE

The Council, with regret, accepted the resignation of Mr. E. Ray Scott, who is leaving MSMS after years faithful service to become the Executive Director of the new Michigan Commission on the Arts.

LOOK- Are **YOU** Protected? . .

By the Comprehensive Group Insurance
plans sponsored for its members by the
Michigan State Medical Society? . . .

Life Insurance . . .
2 plans available including coverage for dependents

LONG TERM DISABILITY . . .
SPECIAL ACCIDENT . . .
Death & Dismemberment up to $100,000

PROFESSIONAL OVERHEAD EXPENSE . . .
Up to $1500 monthly

BEN P. STRATTON AGENCY, INC.
Administrators

P. O. Box 547
Lansing, Mich.
48093

Butazolidin® alka

phenylbutazone	100 mg.
dried aluminum hydroxide gel	100 mg.
magnesium trisilicate	150 mg.
homatropine methylbromide	1.25 mg.

In rheumatoid arthritis—effective the with minimal chance of G-I upset

Therapeutic Effects
Fifty to 75% of patients obtain major relief of arthritic symptoms, as reported by numerous clinicians. In addition, the problem of gastric upset—a major problem with certain other oral antiarthritic agents—is minimized by the presence of antacids and an antispasmodic in the formulation.

Improvement is generally seen within 3 to 4 days, and trial therapy need not be continued beyond a week. Relief of pain is followed quickly by resolution of inflammation and improved joint function. Relief of symptoms is often accompanied by increased appetite, gain in weight and an improved sense of well-being.

The initial response is usually maintained without dosage increases; indeed, initial dosage is often reduced for maintenance purposes.

Salicylate or steroid therapy can usually be diminished or, in some instances, eliminated.

Contraindications
Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. Because of the increased possibility of toxic reactions, the drug should not be given when the patient is senile or when other potent chemotherapeutic agents are given concurrently. Large doses of Butazolidin alka are contraindicated in patients with glaucoma.

Precautions
Before prescribing, the physician should obtain a detailed history and perform a complete physical and laboratory examination, including a blood count. The patient should be kept under close supervision and should be warned to report immediately fever, sore throat, or mouth lesions (symptoms of blood dyscrasia); sudden weight gain (water retention); skin reactions; black or tarry stools. Regular blood counts should be made. The drug should be used with greater care in the elderly.

Warning
If coumarin-type anticoagulants are given simultaneously, the physician should watch for excessive increase in prothrombin time.

Pyrazole compounds may potentiate the pharmacologic action of sulfonylurea and sulfonamide-type agents and insulin. Patients receiving such concomitant therapy should be carefully observed for this effect.

Adverse Reactions
The most common adverse reactions are nausea, edema and drug rash. The drug may reactivate a latent peptic ulcer. Infrequently, agranulocytosis, generalized allergic reaction, stomatitis, salivary gland enlargement, vertigo and languor may occur. Leukemia and leukemoid r
have been reported but cannot de
attributed to the drug. Thrombocy
purpura and aplastic anemia are a
sible side effects. Confusional stat
agitation, headache, blurred visior
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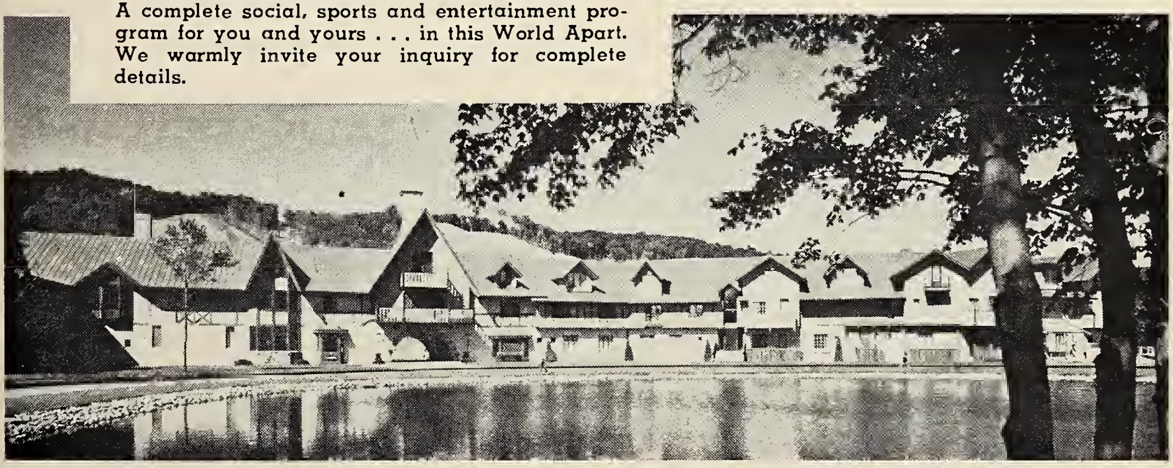

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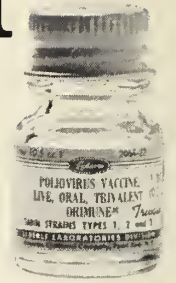

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ORIGINAL
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A Review of Narcotic and Non-Narcotic Analgesics

By T. J. DeKornfeld, M.D.*
Ann Arbor

During the past 10 years improved research echniques and a marked increase in the interest ı this field have occasioned the introduction of very large number of new narcotic and non-arcotic analgesics.

Today, once again, we seem to be standing on he threshold of significant new advances in this rea and therefore it would seem timely to review me of the presently available compounds in the ght of the new developments and to indicate me of the yet experimental drugs which may on be made available to the profession.

The analgesic drugs are generally divided into vo major groups on the basis of their addiction otential. In one group are those drugs which have relatively high addiction potential and therefore ave to be handled according to the requirements f the Harrison Narcotic Act. All the remainder f the analgesics, mild or powerful, are considered be non-addicting or of such low addiction poential as to be classified as lying outside the jurisiction of the Act.

Although pharmacologically this division may metimes appear somewhat arbitrary, clinically it s eminently practical and it will be followed for he purposes of this discussion.

A. THE NARCOTIC ANALGESICS (TABLE I).

Morphine sulfate is still the standard, narcotic nalgesic and is used in most instances as the comparative drug in analgetic research. Morphine is nsurpassed in its power to alleviate pain and to llay fear. It is still regarded, by most experts in his field, as the narcotic of choice in most patients who are not allergic to it. In analgesically equipotent doses the side effects caused by morphine re comparable to those produced by any other arcotic.

Demerol (Meperidine): Clinically introduced as non-addicting, non-respiratory depressant, smooth muscle relaxant, narcotic analgesic, it actually lacks ll these virtues and is similar to, although generally less satisfactory than morphine as an analgesic.

Dilaudid (Dihydromorphone): In equipotent doses this drug is essentially indistinguishable from morphine, although it may have a slightly shorter duration of action.

Numorphan (Oxymorphone HCl): This is a highly potent narcotic, quite similar to morphine. It has been accused of producing a high incidence of nausea and vomiting.

Levodromoran (Levorphanol tartrate): Reasonably satisfactory orally. Has longer duration of effects than morphine.

Alvodine (Piminodine): Offers no advantage of any kind.

Prinadol (Phenazocine): One of the most potent respiratory depressants. Has very little to offer.

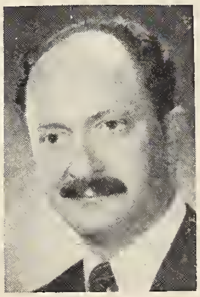
Nisentil (Alphaprodine): Its very short duration of action makes this drug of little use clinically except in certain obstetrical or surgical procedures.

Leritine (Anileridine): This drug is similar to Demerol but may be more active orally than most narcotics.

Codeine: Probably the most widely used narcotic. An excellent antitussive in doses of 15 to 30 mgms. The minimum effective analgesic dose in adults is 60 to 90 mgm.

Nalline (N-allylnormorphine): This interesting compound recently removed from the restricted list is a nonspecific narcotic antagonist. It is a depressant drug, in its own right, and it produces withdrawal symptoms in addicts. It should therefore be used only when clearly indicated in narcotic intoxications. Mixtures of narcotics and narcotic antagonists, highly recommended a few years ago, have no place in clinical medicine.

Almost all narcotics are effective primarily after parenteral administration. Given orally, the results obtained are erratic and generally disappointing. All narcotics are respiratory depressants and



The Author
T. J. DeKornfeld, M.D.

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*Associate Professor, Department of Anesthesiology, University of Michigan School of Medicine, Ann Arbor, Michigan.

should be used only with extreme caution in patients with obstructive or congestive respiratory disorders.

B. THE NON-NARCOTIC ANALGESICS (TABLE II)

The non-narcotic analgesics are defined as mild to moderately potent pain relieving drugs which do not produce physical dependence. It is obvious that these drugs play a very important role in the management of mild and moderately severe acute pain and particularly in the management of moderately severe and severe chronic pain. Unfortunately to date the non-narcotic analgesics made available to the public, either "over the counter" or by prescription sale, are either practically worthless or have a relatively high incidence of side effects.

Aspirin: By far the world's most widely used drug, it is generally underestimated by the medical profession. Being both an effective analgesic and anti-inflammatory drug it has been shown to be able to relieve pain in the post-operative and post-partum periods, as well as the pain of malignancy, arthritis and other inflammatory states. In a number of carefully controlled studies aspirin was found to be indistinguishable from allegedly more potent oral analgesics including narcotics.

There is no convincing evidence that the addition of an alkalizing agent improves the clinical performance of aspirin in any way. Nor do the so-called buffered aspirins have a lower incidence of gastrointestinal side effects.

The addition of phenacetin and caffeine to aspirin does not seem to increase the analgesic potency but may increase the gastrointestinal irritation potential. Phenacetin has also been implicated in the production of necrotic lesions in the kidn but only in cases of prolonged and extensive usag The occasional consumption of the very popul "A.P.C." preparations seems to be quite safe ar indeed, APC is still available "over the counte

There are a large number of new aspirin pre arations but there is no evidence that these ne formulations are in any way superior to plain a pirin and of course they tend to be far more e pensive than the original product.

Zactane (Ethoheptazine): This drug is such mild analgesic that, in at least one controlled clin cal study, it was indistinguishable from placebo.

Zactirin (Ethoheptazine plus Aspirin): Has th benefit of aspirin and is therefore a satisfacto analgesic, although aspirin is available at a muc lower cost.

Darvon (d-propoxyphene): The enormous popu larity of Darvon cannot be explained on the bas of experimental evidence. It is an active althoug mild analgesic which seems to be in the aspiri class as far as analgesia is concerned. It is ma keted in combination with both aspirin and AP and indeed, these combinations have replaced plai Darvon to a very considerable degree.

The Muscle Relaxant Analgesics: Within the pas few years a number of these compounds have bee introduced. Methocarbamol (Robaxin), Carisopro dol (Soma, Rela) and Phenyramidol (Analexin) ar alleged to have analgesic and skeletal muscle re laxant properties. These claims are based primaril on laboratory animal experience or on uncontrolle testimonial type clinical "studies." The few con trolled studies available seem to indicate that i man, and in the dosages recommended, these drug are neither muscle relaxants nor analgesics.

TABLE I
Narcotic Analgesics

Trade Name	Generic Name	Manufacturer	Dose Parenteral	Price*
Morphine sulfate		Numerous	10-15mg	$0.09/ 15mg amp
Demerol	Meperidine HCl	Winthrop Lab.	50-100mg	0.35/ 100 mg amp
Levodromoran	Levorphanol tartrate	Roche Lab.	2mg	0.21/ 2mg amp
Dilaudid	Dihydromorphone	Knoll Pharma.	2mg	0.25/ 2mg
Numorphan	Oxymorphone HCl	Endo Lab. Inc.	1.0-1.5mg	0.46/ 1.5 mg
Prinadol	Phenazocine	Smith Kline & French Lab.	2mg	0.22/ 2mg
Alvodine	Piminodine	Winthrop Lab.	20mg	0.32/ 20mg
Leritine	Anileridine	Merck Sharp & Dohme	25-50mg	0.36/ 50mg amp
Codeine		Numerous	30-60mg	0.12/ 60mg
Nisentil	Alphaprodine	Roche Lab.	60mg	0.36/ 60mg

*Single dose price, retail to hospitals

TABLE II
Non-Narcotic Analgesics

Trade Name	Generic Name	Manufacturer	Price*
A.S.A.	Aspirin	Numerous	$0.29
Bayers A.S.A.	Aspirin	Sterling Drug	0.79
Bufferin	Buffered aspirin	Bristol Lab.	1.39
Anacin	Compound aspirin (A.P.C.)	Whitehall Pharm. Co.	1.25
Excedrin	Compound aspirin (A.P.C.)	Bristol Lab.	1.49
Empirin	Compound aspirin (A.P.C.)	Burroughs Wellcome & Co.	1.35
Zactane	Ethoheptazine citrate	Wyeth Lab.	6.00
Zactirin	Ethoheptazine citrate with aspirin	Wyeth Lab.	7.90
Darvon	d-Propoxphene HCl	Eli Lilly & Co.	9.50
Darvon Compound 65	d-Propoxphene HCl with aspirin, phenacetin, & caffeine	Eli Lilly & Co.	9.82

*Price-retail for bottle of 100 tablets or capsules

Placebo: No discussion of analgesics would be complete without mention of the placebo. It is well recognized that in many clinical situations, even where pain is undoubtedly present, a placebo by mouth or, particularly, by injection may cause a significant degree of pain relief. The incidence of placebo reactions in some studies has been as high as 30 to 50 per cent of the patients. It is therefore well to remember that placeboes have a definite place in the armamentarium of the practicing physician and also that any study that does not include placeboes or at least an active-standard drug as comparison cannot be accepted by the modern standards of clinical investigation.

C. EXPERIMENTAL ANALGESICS.

Most of the investigative activity in this field is now limited to a search for a potent, orally active, non-addicting analgesic.

Talwin (Pentazocine, WIN 20,228) is a narcotic antagonist, similar in its pharmacological behaviors to Nalline. It is a moderately potent analgesic without causing any significant degree of central nervous system stimulation. It is active orally and parenterally and it is not considered an addictive drug. This drug is a respiratory depressant and does cause sedation. If licensed for general use its only real advantage will be the freedom from the paperwork inherent in prescribing narcotics.

Levoprome (Methotrimeprazine): This most interesting compound marketed in Canada under the name of Nozinan® is the only phenothiazine derivative which is also a true analgesic. The compound has no addiction liability and is not a respiratory depressant. Its only major disadvantage, which has kept it from the United States market so far, is its causation of marked orthostatic hypotension. This property will certainly curtail its usefulness in ambulatory patients. There is some indication that orthostatic hypotension may disappear after repeated administration.

Several other compounds are currently in various stages of clinical trials and some are already awaiting FDA clearance. As far as is presently known none of these drugs seem to present significant advances in the clinical management of pain.

* * *

IN SUMMARY, IT must be emphasized, that the two oldest analgesics, morphine and aspirin, are still the most generally satisfactory members of their respective groups. The newer narcotic and non-narcotic analgesics are only equal to, or inferior to, the standard drugs and yet are frequently many times more expensive. There are few areas of clinical medicine where more wildly extravagant claims have been made by manufacturers and their advertising agencies and it is most decidedly in the best interest of all physicians and their patients to ignore the shrill and blatant voice of commercialism. The old drugs are still frequently the best drugs and almost always the cheapest drugs.

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ORIGINAL
SCIENTIFIC
ARTICLE

Cordan and Synalar-Total Body Occlusive Dressings

By CARL COHEN, M.D.
Of Cincinnati

The treatment of dermatoses with topical medications covered with dressings (occlusive dressings) has long been used. However, it has been only in the past few years that this modality and its modifications using topical steroid products has been employed in the therapy of localized and disseminated cutaneous lesions. This type of therapy is called surface depot therapy by Scholtz.[1]

It was the purpose of this study to investigate this method of therapy covering over at least 90 per cent of body surface area treatment, for therapeutic results, associated toxicities, electrolytic changes and corticosteroid absorption.

* * *

IN THIS STUDY, the entire body, excluding the face, scalp, genitalia, and for the most part, the hands and feet, was inuncted with a thin layer of the topical corticosteroid medication and covered with 1/20th strength Eau d'Alibour dampened dressings. A plastic, pliable film (Saran) was then used to encase the steroid and the dressing. The dressings were then secured with a heavy, reed-roll webbing bound around the plastic covering.

Surface depot treatment was administered with two corticosteroid products: (1) fluocinolone acetonide cream (Synalar) 6 alpha, 9 alpha difluoro, 16 alpha hydroxyprednisolone acetonide, in concentrations of .025 per cent and .01 per cent; (2) flurandrenolone-neomycin lotion (Cordran) 6 alpha-fluoro, 16 alpha-hydroxy hydrocortisone, 16, 17 acetonide, .05 per cent.

High effectiveness in topical treatment is conferred by fluorine in the beta ring of the steroid nucleus and in acetonide at carbons 16 and 17. Flurandrenolone has one beta ring fluoride and fluocinolone has two. They are both acetonides. The inunction was repeated once daily for six days with the fluocinolone cream and flurandrenolone lotion. With each inunction, approximately 30-45 grams daily of the creams were used and approximately 30 cc of the lotion.

As a therapeutic measure, surface depot with these compounds was used over 90 per cent of the total body surface on the 20 separate treatment periods to 20 patients. They ranged in age from seven to 82 years. Five were treated with the flurandrenolone-neomycin lotion, ten with the .025 per cent fluocinolone cream, and five with the .01 per cent cream.

* * *

THE DERMATOSES treated included acute contact dermatitis, psoriasis, erythroderma, stasis eczema, atopic eczema, lichen planus, infectious eczematoid dermatitis, generalized neurodermatitis, pityriasis rubra pilaris, and seborrhoea corporis and capitis. In all these dermatoses, the area of skin involvement by the dermatoses was more than 50 per cent. With inflammation, more topical corticosteroid may be absorbed from this area than from a comparative area of normal skin.

Fluocinolone .025 per cent concentration was used in ten patients daily for six days. Immediate baseline and post-treatment plasma electrolytes, plasma 17 (OH) corticosteroids, urinary 17 (OH) corticosteroids and 17 ketosteroids were done. Blood samples were taken at 8:00 a.m. on two mornings six days apart, and 24-hour collections of urine were performed before the first and immediately after the sixth day of treatment.

Clinically, the four patients with atopic eczema and the one with stasis eczema showed the greatest response to this therapy. Both patients with psoriasis were markedly improved. However, the patient with the psoriatic erythroderma was not benefited, nor was the individual with the pityriasis rubra pilaris. The hypertrophic element was greatly reduced in the patient with lichen planus and no new lesions were observed. There was no clinical evidence of toxicity or other undesirable side effects using surface depot therapy with this steroid.

* * *

LABORATORY VALUES showed no significant change in plasma, sodium, potassium or chloride after surface depot therapy. The concentration of 17 (OH) corticosteroid in plasma decreased in nine of the ten patients from the mean plasma of 17 (OH) corticosteroid level before treatment was begun. The mean decrease was 4.4 micrograms per cent, showing a statistical significance of probability less than .02. The urinary 17 (OH) corticosteroid output decreased in seven of ten patients with the mean decrease of 2.9 milligrams per 24 hours was probably significant. (P is equal to .05.)

From the Department of Dermatology of the College of Medicine of the University of Cincinnati.

The output of urinary 17 ketosteroid dropped in nine of ten patients with a mean decrease of 5.3 milligrams per 24 hours which was significant. (P is less than .01.)

After six days of use with .025 per cent fluocinolone depot treatment, these decreases in steroid values both in plasma and in urine suggested that there may be some absorption of fluocinolone acetonide with subsequent suppression of endogenous steroid output via the pituitary adrenal axis. However, the decrease in steroid levels could simply reflect an overall improvement of the dermatosis or an adaptation by the patient to the experimental conditions either of which might lower metabolic stress and consequently decrease steroid levels.

* * *

FOR FURTHER investigation, more detailed experiments were performed with a lesser concentration of fluocinolone, .01 per cent. A total of five patients were treated with six-day surface depot therapy. The conditions treated included a generalized eczematous dermatosis, a disseminated neurodermatitis, hypertrophic lichen planus, psoriasis, and one patient with seborrhoea capitis and no cutaneous lesions who served as a control. Plasma 17 hydroxy corticosteroids were taken at 8:00 a.m. on two successive days before treatment was begun, on the second, fourth, and fifth days of treatment, and on the third and fourth days after treatment was terminated. Urinary 17 hydroxy corticosteroid and creatinine samplings were taken daily.

After six days of surface depot therapy, the patient with neurodermatitis was free of lesions. The psoriatic and the eczematous patient were improved to the point of being easily controlled as outpatients. The hypertrophic element of lichen planus was resolved and there were, clinically, no further new lichen planus lesions. The patient who had seborrhoea capitis was of special interest, for serving as a control, her plasma and urinary steroid samplings showed no significant norm deviations.

Pre-treatment and post-treatment plasma electrolyte values for all five individuals were within normal range. Statistical correlation for these five patients was done. From the pretreatment mean control, plasma and urinary mean differences, and probabilities for each sampling day were correlated. Our findings indicated no significant differences in either plasma or urine for 17 (OH) corticosteroids. Probability values from statistical formulae showed non-significance. It was concluded that six-day surface depot treatment with .01 per cent fluocinolone cream in this patient group did not produce systemic steroid absorption.

* * *

OF THE FIVE patients treated with flurandrenolone-neomycin lotion, the two with the contact dermatitides were completely cured. The psoriatic was markedly improved. There was a moderate decrease in redness and a slight decrease in scaling in the individual with the erythroderma. There was no clinical benefit observed in the patient with pityriasis rubra pilaris.

Laboratory tests were taken immediately before and immediately after surface depot flurandrenolone-neomycin lotion treatment was begun and terminated. Transaminase, cephalin flocculation, se-

TABLE I.
Total Bodily Inunction—Fluocinolone Acetonide 0.025 Per Cent
7.5-11.25 mg corticosteroid daily for six days

			Plasma (Meq/1)						
Patient	Age	Diagnosis	*	NA	K	CL	Plasma (Mcgm %)	Urine 17 (OH) CS mgm/gm cr/24 Hr.	Urine 17 KS mgm/gm cr/24 Hr.
1. T.J.	10	Pityriasis rubra pilaris	(1)	147	5.4	102	12	11.9	18.3
			(2)	145	4.7	106	10	3.3	10.8
2 E.M.	78	Stasis dermatitis	(1)	141	5.0	100	14	7.7	9.0
			(2)	143	5.1	105	11	5.5	8.4
3. D.P.	7	Atopic dermatitis	(1)	152	4.3	97	5	5.0	9.1
			(2)	152	4.2	100	1	2.5	8.1
4. E.R.	73	Psoriasis	(1)	143	4.9	103	11	6.5	11.5
			(2)	141	5.0	89	9	2.6	2.7
5. B.W.	45	Atopic dermatitis	(1)	143	5.0	90.0	12	3.6	8.9
			(2)	158	4.9	94	3	4.6	3.0
6. R.L.	33	Psoriasis	(1)	148	4.7	100	9	8.8	14.5
			(2)	142	4.5	102	8	6.3	12.7
7. S.B.	21	Atopic dermatitis	(1)	136	4.2	105	19	2.2	7.0
			(2)	147	3.8	103	19	5.8	8.2
8. G.C.	82	Psoriatic erythroderma	(1)	145	4.4	101	20	10.4	8.3
			(2)	142	4.5	102	12	11.6	1.6
9. L.A.	44	Hypertrophic Lichen Planus	(1)	137	5.2	89	16	8.9	19.0
			(2)	142	4.1	94	2	2.4	11.9
10. T.S.	55	Atopic eczema	(1)	139	4.6	99	18	10.9	24.6
			(2)	141	4.9	102	17	8.1	9.4

*(1) Baseline
(2) Treated Sample

Average decrease, Plasma, entire series—4.4 (17 (OH) C)
Average decrease, Urine 17 (OH) C, entire series—2.3
Average decrease, Urine 17 KS—5.2

rum total protein, A/G ratio, BUN and urinalysis values were within normal limits and showed no significant change with treatment indicating no renal or hepatic toxicity. Plasma electrolyte values for all were within normal range. Of the three patients with plasma 17 (OH) corticosteroid assay, all three showed no abnormal change with treatment. In addition, urinary 17 (OH) corticosteroid and 17 ketosteroid levels were not significantly altered during this treatment.

DISCUSSION

The therapeutic efficacy of surface depot therapy is dependent primarily upon two factors: the response of the dermatosis in question to a topical steroid and the activity of the steroid being used. Fluorinated steroid products rank high in potency among commercially available topical steroids and surface depot occlusion greatly enhances their percutaneous absorption, approximately a hundredfold. It is supposed, without proof, that surface depot technique retains a medication in the skin for a prolonged period of time. Confirmation of this, however, awaits further labeled C^{14} steroid tracer studies. We are initiating this type of surface depot therapy with C^{14} fluocinolone.

With a potent fluorinated corticosteriod, there may be some inconstant changes in assay level from such an extensive use as 90 per cent of body surface. We have observed this only in certain patients and only with extensive surface depot, not with the relatively smaller areas as Scoggins[2] indicates. With a concentration of 0.01 per cent, no changes in assays were found, nor were there changes observed with the flurandrenolone lotion.

Other investigators have found no assay evidence of pituitary suppression with extensive surface depot therapy routines. Clinically, we have observed no evidence of such suppression, not only in this series but in patients under surface depot therapy for periods prolonged into weeks and months. Therefore, we do not believe these changes in plasma (less subject to variation) or in urinary sterids to be significant clinically. Those figures of hormone assay should not be used as arguments against the use of this excellent therapy. Certainly, topical corticosteriods, even with techniques of extensive surface depot therapy, are much safer than the use of oral corticosteriods.

Surface depot therapy, nevertheless, is not without secondary phenomena. There have been described occlusional folliculitis, bacterial and yeast infections, plastic pliable-film irritation from the

TABLE IIa.
Total Body Inunction—Fluocinolone Acetonide 0.01 Per Cent
3.0-4.5 mg corticosteroid daily for six days

			Plasma 17 (OH) CS Mcgm%						
Patient	**Age**	**Diagnosis**	**T-2**	**T-1**	**T&2**	**T&4**	**T&5**	**PT&3**	**PT&4**
1. H.L.	57	Infectious eczematoid dermatitis	10	20	16	15	10	11	10
2. B.S.	37	Seborrhoea capitis	13	16	21	14	18	14	15
3. A.S.	43	Generalized neurodermatitis	13	11	14	13	13	14	13
4. W.P.	41	Lichen Planus	16	18	10	13	11	23	14
5. R.R.	36	Psoriasis	18	13	18	6	14	20	9

T— = days before therapy
T& = days of therapy
PT = days post therapy

TABLE IIb.
Total Body Inunction—Fluocinolone Acetonide 0.01 Per Cent
3.0-4.5 mg corticosteroid daily for six days

			Urinary 17 (OH) CS—mgm/gm cr/24 hr											
Patient	**Age**	**Diagnosis**	**T-2**	**T-1**	**T&1**	**T&2**	**T&3**	**T&4**	**T&5**	**T&6**	**PT&1**	**PT&2**	**PT&3**	**PT&4**
1. H.L.	57	Infectious eczematoid dermatitis	2.9	1.8	2.1	2.4	4.3	3.0	1.5	0.82	2.3	4.0	3.0	4.0
2. B.S.	37	Seborrhoea capitis	3.1	3.2	2.7	3.0	2.8	4.6	4.0	4.0	4.7	1.7	2.4	3.4
3. A.S.	43	Generalized neurodermatitis	2.0	2.4	1.7	1.8	1.4	4.1	3.2	2.8	2.8	1.9	1.8	2.5
4. W.P.	41	Lichen Planus	1.2	1.4	2.9	1.8	2.4	1.4	1.7	2.4	1.7	2.8	2.5	1.9
5. R.R.	36	Psoriasis	1.7	3.2	3.4	1.2	2.5	5.3	2.6	1.7	3.0	1.1	1.9	3.3

T— = days before therapy
T& = days of therapy
PT = days post therapy

TABLE III.
Total Body Inunction—Flurandrenolone 0.05 Per Cent and Neomycin 1.0 Per Cent
15 mg corticosteroid daily for six days

Plasma Values					
Patient	T.L.	R.K	T.B.	J.S.	D.W.
Age	48	56	42	49	44
Diagnosis	Erythroderma	Psoriasis	Cont. Derm.	Cont. Derm.	P.R.P.
NA	(1) 145	(1) 154	143	141	145
	(2) 139	137	133	132	140
KK	(1) 9.4	4.5	4.6	4.1	4.0
	(2) 4.1	3.7	4.5	4.0	3.8
CL	(1) 103	106	107	103	107
	(2) 101	105	103	101	104
Transaminase (units)	(1) 15	10	12	8	14
	(2) 20	8	22	22	13
Cephalin Flocculation	(1) 0	0	0	0	0
	(2) 0	0	0	0	0
Total Protein (gm %)	(1) 6.3	8.2	8.1	7.6	6.8
	(2) 7.0	6.9	7.8	7.5	7.1
A/G Ratio	(1) 3.5/2.8	4.2/4.0	3.8/4.3	4.2/3.4	5.0/1.8
	(2) 4.2/2.8	4.3/2.6	3.6/4.2	3.8/3.7	4.9/2.2
Bun (mg %)	(1) 13	14	8	15	16
	(2) 20	15	11	10	14
17 (OH) C (mcgm %)	(1) 10	10	9	not done	not done
	(2) 12	10	6	not done	not done
Urine Values					
17 (OH) C (mgms/gm CR/24H)	(1) 3.9	3.7	2.1	2.5	3.7
	(2) 2.3	7.2	3.3	5.4	1.5
17-(KS) (mgms/gm CR/24H)	(1) 16.9	22.8	7.5	9.3	10.9
	(2) 15.4	19.0	5.1	7.0	10.3

(1) Base Line Studies Before Therapy
(2) After Six Days of Daily Repeated Applications

overlapping material, ready inflammability of the plastic material with subsequent liberation of noxious, long-chain fluorinated-hydrocarbon fumes which is obviated with the Saran. Striae have been noted and the isomorphic response of Koebner has occured. Miliaria is often produced and a foul odor with removal of the dressing is an almost constant finding. Hyperthermia has occured and a contact dermatitis to either the base or an incorporated topical antibiotic may result.

* * *

IN OUR SERIES, the use of diluted Eau d'Alibour solution, we feel, minimized the tendancy toward secondary infection. We had no instance of this in our series in the neomycin studies. The addition of a topical antibiotic complemented this. A common complaint was pruritis, which was probably due to the occlusiveness of this therapeutic technique with its subsequent heat and sweat retention. Previously, in infants and young children, not in adults, we had observed hyperthermia. This may be due to the combination of an immature heat regulating center in association with a greater amount of insensible perspiration dissipated per unit area. In this series in adults there was no evidence of interference with temperature regulation with these extensive dressings.

Because surface depot technique is effective with the steriods, such techniques may be used with other topical medications. Adaptations using other topicals, such as, vitamin A, the tars, antibiotics, keratolytics, griseofulvin, fungicidal and fungistatic agents alone and in combinations, seem to be worthwhile for clinical evaluation.

SUMMARY

Two corticosteroids, fluocinolone, and flurandrenolone were used in surface depot therapy techniques covering over 90 per cent of the body surface in 20 patients. Excellent therapeutic responses were produced in most. Detailed laboratory studies of urinary and plasma hormone assays, tests of hepatic and renal function showed no clinically significant findings. For dermatologic conditions responsive to corticosteriods, surface depot therapies

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are effective and less productive of reactions than oral corticosteroids.

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Fluocinolone furnished by Dr. Kenneth Dumas, Syntex Laboratories, Inc.; Flurandrenolone furnished by Dr. A. S. Ridolfo, Eli Lilly Co.

Trade names are for identification only and do not represent an endorsement of the Public Health Service or the U. S. Department of Health, Education and Welfare.

Voices View on Goals

The primary purpose of the state medical journal is to support in any and all ways, the State Medical Association, and its main line of communication by means of the written word. Our journals will be more successful if we keep this goal constantly before us and do not change course to seek some secondary goal. We are all prone to become engrossed in seeking reports of original scientific discoveries, superior reviews or excellent medical writing in general, or we are anxious to pursue attractive, formal or elegant style, and thus tend to lose sight of our main goal. We must concentrate on bringing information from nation, state and county levels to the individual member.

Carl B. Lechner, M.D.
Medical Editor
Pennsylvania Medicine

The Task Ahead . . .

"Business and professional men must realize that all of our citizens do not understand our systems and institutions. We must not continue to assume that everyone understands what we are talking about, particularly when we discuss our economic system. There is almost no discussion of private enterprise, the logic behind it or the advantages of it, in our early and formative years in school. The members of our business and professional community have a lot of education and selling to do if they expect to maintain any degree of respect in the years to come." (S. John Byington, in *Michigan Pharmacist*, Vol. 2, No. 12.)

Suggested Reading

Are you curious about the personality aspects of the smoking and health problem? If so, you may wish to borrow from the MSMS Library the new Basic Books, Inc., publication, "Smoking, Health and Personality," by H. J. Eysenck, Professor of Psychiatry at Maudsley Hospital, London. Just write to MSMS, Box 152, East Lansing 48824.

IDEA WORKS IN OHIO

The Ohio State Medical Society passes along this advice to doctors who are tired of losing time and money filling out requested forms. One physician has found very successful the following statement, mailed routinely when completed forms and records are requested: "Dear Sirs: Upon receipt of your check for $........, the customary fee of this office for the service you have requested, plus all the enclosed papers, the report will be completed and forwarded to you without delay."

Appreciative

"I never walk out one of the hospitals which I visit in the daily routine, without an awareness of what a great gift has been given to us through medical science. I think of consecrated and dedicated men of research, and the men who practice the healing art of medicine. We on occasion gripe about our doctors, but I think we ought to bow in gratitude and thank God for them, and for the healing ministry that they bring, thankful that they are here when we need them to help us, to restore us to minister to our physical needs."

Excerpted from sermon by
Rev. Wallace Robertson
Peoples Church, East Lansing

ORIGINAL SCIENTIFIC ARTICLE

Barium Enema Study With the Rocking Method

By N. J. Theisen, M.D.
Escanaba

Patients experience both spasm and pain during the administration of barium enema study with the conventional procedure.

Over the past four years a rocking method of administering the barium enema has been performed at St. Francis Hospital, Escanaba, in more than 2,000 patients; and since this method was instituted, there have been markedly less complaints about spasm and pain, less spasticity was observed during fluoroscopy; also the method allows considerable reduction in examination time in radiation exposure as well.

TECHNIQUE

The patient is supine, leaning about 45° to his left side when the enema is begun. The right arm crosses the patient's chest and with his right hand he holds onto the left edge of the examination table, also his right knee is elevated and flexed. The patient is instructed to actively rock right and left using his right arm and right leg; the radiologist controls the amount of motion easily by placing his right hand on the patient's right knee or left hand on his right upper arm depending on the type of fluoroscopic screen. He may add to the to and fro motion or indicate changes in position during this first phase of the examination. The colon is not at rest during the filling procedure which may appear as an initial difficulty; however, better acquaintance with this technique allows the radiologist to obtain a stereoscopic effect of the loops of colon, particularly of the sigmoid. This effect is actually an advantage in orientation during examination. The motion as well as filling may be halted at any time if indicated, and palpation and spot films applied.

When the descending colon is filled past the splenic flexure the patient is rotated to his right side and now the left arm and left hand reach to the right edge of the table to assist in further rocking motion to the right. In this position the barium flows past the hepatic flexure into the ascending colon.

To insure fast and complete filling of the cecum and terminal ileum the radiologist now places his gloved fist under the patient's right flank, and the patient turns into an almost direct right lateral position, and rocks himself against the radiologist's fist.

In effect the patient is massaging his own cecum, rather than the radiologist administering pressure without knowing how much pain and discomfort the patient can withstand. Only about four to six to and fro motions will be necessary to obtain filling of this area in the average case. The barium flow is then stopped and the entire colon is surveyed and local palpation and spot films may be added as desired.

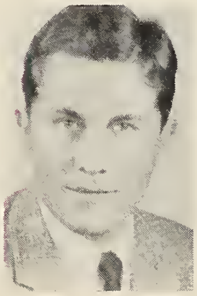
Using fine suspension barium (Intropaque) in concentration of 240 cc of powder per quart of solution (which has a viscosity higher than regular barium), 36 inches of hydrostatic pressure and 3/8 inch tubing with 1/4 inch plastic disposable enema tip (or inflatable bulb catheter with 1/4 inch lumen), and without agitation, we obtain a flow rate of 1 minute 40 seconds per quart.

Using the rocking method, 102 consecutive patients were tested for filling time; only 2 were excluded from the study because of spillage during the examination which made reinsertion necessary.

The filling time averaged 91.4 sec. sixty per cent were between one and two minutes, fifteen per cent each were below one and above two minutes. The shortest filling time was in a 34-year-old male with 30 seconds, and the longest in a 78-year-old male—210 seconds. The last patient had a stenotic sigmoid due to diverticulitis.

The time study seems to corroborate the impression that loops and curvatures of the colon are easier and faster filled using the movements as described. In fact, the moving column of barium seems to open a loop ahead easier without applying pressure from a distended portion to a collapsed portion of the colon around a kink.

Obstacles whether due to retained fecal matter or due to stenosis or organic lesions are easier to overcome. In one patient, who had a carcinoma of the sigmoid with almost complete obstruction, the length of the stenosis and the proximal border of the lesion



The Author
N. J. THEISEN, M.D.

Doctor Theisen is associated with the St. Francis Hospital, Escanaba.

could not be visualized with the patient at rest, but were demonstrated after rocking motion was used.

Similar rocking is applied for infants in examination for obstruction and intussusception. Here a sheet wrapped around the legs immobilizes the patient and the radiologist rocks the patient to and fro with his right hand but does not apply palpation pressure.

The rocking method may be used for cleansing enemas as well, with favorable results; the patient rocks to the left for about 30 seconds and then for about 30 seconds to the right side.

SUMMARY OF ADVANTAGES

1. Ease of administration and control of position.
2. Saving of time and exposure to the patient.
3. Viewing with stereoscopic effect while colon is in motion.
4. Considerably less pain and spasm experienced by the patient.

SUMMARY

A rocking method for barium enema examination of the colon is described. The patient tilts about 45° from the recumbent position to his left and actively rocks right and left, guided by the radiologist, until the left colon is filled; then he tilts and rocks to the right for filling of the right colon. The cecum is massaged by the patient himself while he rocks onto the radiologist's gloved fist.

The filling time of the colon measured for 100 patients averaged 91.4 seconds with fine suspension barium (Intropaque) through ¼ inch plastic enema tip.

The method is advantageous in saving time and exposure, allowing the radiologist to obtain a stereoscopic effect of the colon in motion and causing considerably less spasm and pain to the patient.

M.D. Placement Service

Michigan Health Council

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A Physician's Prayer

By J. H. Ahronheim, M.D.
Jackson

(The following prayer was written by Docto Ahronheim for the monthly W. A. Foote Memoria Hospital bulletin.)

Heavenly Father, I thank Thee for the many favors which Thou has bestowed upon me, for the privilege of probing into the mysteries of life, for the mind to understand the functions of the body, for the right and ability of sharing my knowledge with my fellow physicians.

Often a heavy burden is placed upon my shoulders when my actions entail a decision of death or life: for this task, Oh Lord, grant me wisdom and strength of judgment. Give me the vision to see the beauty and purposefulness of the body, Thine own creation.

Let me not forget that the human body is sacred and is entrusted to me with the unspoken expectation that it be treated with dignity and respect. Help me to stay on the path of truth and veracity and let me always remember that my noblest quality is integrity, more so even than knowledge and wisdom.

Help me to make all my decisions without prejudice and vanity, and make me mindful that others may know better than I, irrespective of age and position. Give me strength to defend my beliefs when I think them to be right, but give me humility to concede to others when I find myself wrong. Help me in my endeavor to prolong life, but give me the courage to abstain from vain efforts when Thou, in Thine never-ending wisdom, hast decreed that life has reached its end.

Endow me with compassion for those who are beyond human help. Give me kindness of heart for those who work under my guidance. Keep my heart from becoming hardened when, in the daily routine of my work, I act indifferently toward those who seek my help.

Make me mindful that knowledge never ends and, that ceasing to learn, means regressing. For all these favors, Oh Lord, I will be grateful, now and for evermore. Amen.

AFTER 107 YEARS

Kalamazoo State Hospital's Female Center Building soon will be torn down after 107 years of service. The 310 remaining patients in the building were moved out by April 1.

The four-story structure, built of sun-dried brick made on the site, was the initial building of the first state institution for the insane in Michigan. The planned capacity of the building was 300; during World War II, it housed as many as 765 patients.

SPECIAL ARTICLE

TB X-ray Reports Now Mandatory

By Michigan Department of Public Health

As pointed out several months ago, Michigan physi- ians have new legal responsibilities related to the eporting of chest x-rays suspcious of pulmonary uberculosis. As prescribed in Section 20, Act 123, P.A. 1965, all such x-ray findings are to be reported o the Director of the Michigan Department of Public Health.

Policy has now been established for the execution of this reporting. The rules and regulations are as ollows:

R 325.896

Sec. 6. (1) Every licensed member of the healing arts and very hospital or laboratory taking or interpreting chest -ray films shall complete form K-124, "Report of Chest X-rays Suspicious for Tuberculosis," on or before the fifth f each month for the preceding month. This form may e obtained from the Division of Adult Health, Michigan Department of Public Health. The completed form shall be forwarded to the director of the local full-time health department in whose jurisdiction the reporting physician, hospital or laboratory is located. The reports shall be considered confidential and not as public records.

(2) If no reportable x-ray findings are obtained during any month, every licensed member of the healing arts and every hospital or laboratory taking or interpreting chest x-ray films shall submit form K-124 with a statement to this effect on or before the fifth of each month for the preceding month.

(3) The director of the local full-time health department, after consultation with the private physician responsible for the care of the patient whose chest x-ray shows suspicious findings, shall determine such additional information as may be may be necessary to complete the evaluation of the patient to determine his status with regard to tuberculosis. Upon completion of the evaluation, the director of the local full-time health department shall report the results to the state director of health.

The form to be employed has been designated "M.D.P.H. Form K-124," and supplies of this form are available upon request from the Division of Adult Health, Michigan Department of Public Health, in Lansing.

Specific operating procedures and the designation of responsibilities for accomplishing the actual reporting are outlined below.

Who	*Does What*	*When*
Person taking or in-erpreting chest x-ay films	Completes Form K-124, *Report of Chest X-rays Suspicious of Tuberculosis,* listing individuals whose chests were x-rayed during the month. (If no reportable x-ray findings are obtained, a statement to this effect should be noted on the form.) Forwards the form(s) to the local health officer in his area.	On or before the fifth of the following month.
Local health officer	Forwards Form K-124 to the Pulmonary Disease Section, Division of Adult Health, Michigan Department of Public Health, *after placing the letter "S" immediately following the names of persons already under supervision.*	Upon receipt of Form K-124 from reporting agencies in his area.
Michigan Department of Public Health	Initiates an Epidemiologic Report (K-605) on all suspects not already under supervision. Refers same to local health officer for evaluation and follow-up.	Upon receipt of Form K-124 from local health officers.
Local health officer	Consults with the physician responsible for the care of the suspect. Makes certain that the suspect has been properly evaluated by the physician to determine his status with regard to tuberculosis. Reports the results on the disposition copy (green) of the Epidemiologic Report.	Upon receipt of Epidemiologic Report from the Michigan Department of Public Health.
Michigan Department of Public Health	Edits and prepares the ER form for data processing. Obtains an annual tabulated report of this program for evaluation purposes. Sends report to local health officers.	After disposition copies of the ERs are returned by the local health officer.

State Medical Society HEALTHMOBILE
Service in Medicine

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Learn about Progress in Medicine . . .
Two Exhibits Show Causes of Death
A Century Ago . . . And Today

Leading Causes of Death in Michigan Today—Life Expectancy 70

Five Leading Causes of Death in Michigan

	Total	Rate Per 100,000
Heart	27,330	337.3
Cancer	12,017	148.4
Stroke	7,911	97.6
Accidents	4,361	53.8
Diabetes	2,048	25.2

Population estimate—8,100,000

Symptoms and Treatment

Heart Disease

Symptoms: Chest pain; edema; rapid, forceful or irregular heart beats; cyanosis; shortness of breath; fatigue.

Treatment: Drugs, surgery, diet.

Cancer

Symptoms: Weight loss, bleeding from body orifices, pain, abnormal lumps or masses.

Treatment: Surgery, radiation, drugs.

Stroke

Symptoms: Headache, dizziness, drowsiness, vomiting, convulsions, mental confusion, loss of muscular control, coma.

Treatment: Drugs, surgery, diet.

Accidents

On the highway, in the home, at work, on the farm.

Treatment: Prevention—in terms of increased public education, use of automobile seat belts, improved safety engineering, etc.

Diabetes

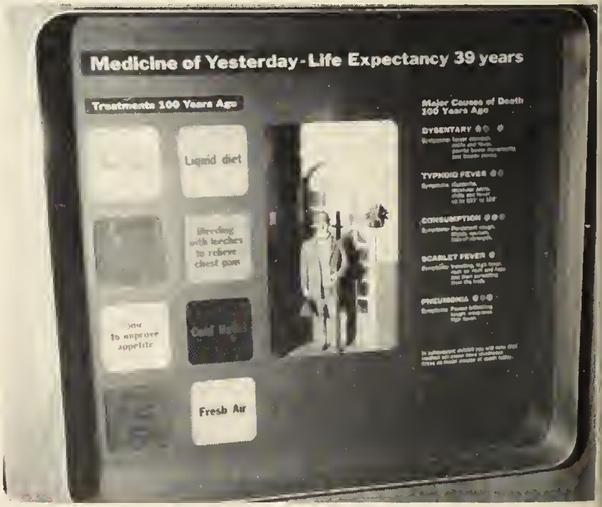
Symptoms: Weight gain; tired, "run-down" feeling; excessive thirst, frequent urination; nonhealing sores or boils; changes in vision; numbness in fingers and toes.

Treatment: Insulin, proper diet.

Medicine of Today-Life Expectancy 70 years
Treatments Today
Drugs
Diet
Surgery
Research
Faith
Major Causes of Death Today
HEART DISEASE
CANCER
STROKE
ACCIDENTS
DIABETES

ABOVE—Healthmobile exhibit shows treatments which are effective today against leadin causes of death.

BELOW—Healthmobile exhibit describes th few treatments of 100 years ago, when life expectancy was 31 years less than it is today.


Medicine of Yesterday-Life Expectancy 39 years
Treatments 100 Years Ago
Liquid diet
Bleeding with leeches to relieve chest pain
to improve appetite
Fresh Air
Major Causes of Death 100 Years Ago
DYSENTARY
TYPHOID FEVER
CONSUMPTION
SCARLET FEVER
PNEUMONIA

Leading Causes of Death 100 Years Ago— Life Expectancy 39

(There are no Michigan figures from 100 years ago. The earliest were for 1867.)

First Ten Leading Causes of Death as Reported in State Health Department Statistics for the years 1867, 1868, 1869, 1870

1867	1868	1869	1870
Consumption	Consumption	Consumption	Consumption
Typhoid Fever	Infantile	Typhoid Fever	Scarlatina
Pneumonia	Typhus Fever	Pneumonia	Typhoid Fever
Dysentery	Dysentery	Old Age	Diarrhea
Old Age	Pneumonia	Diarrhea	Pneumonia
Dropsy	Diarrhea	Scarlatina	Dysentery
Heart Disease	Old Age	Heart Disease	Old Age
Casualty	Remittent Fever	Fever	Convulsions & Fits
Intermittent Fever	Cephalitis	Dropsy	Heart Disease
Brain Disease	Casualty	Dysentery	Dropsy

Symptoms and Treatment

Dysentery
Symptoms: Upset stomach, chills and fever, painful bowel movements and bloody stools.
Treatment: Bed rest and bland, liquid diet; surgery required in event of bowel obstruction.

Typhoid Fever
Symptoms: Headache, muscular pains, chills and fever of 103° to 105°.
Treatment: Liquid diet; cold baths; quinine sometimes; opium sometimes.

Consumption
Symptoms: Persistent cough, bloody sputum, loss of strength.
Treatment: Tonics to improve appetite; sedatives, fresh air, rest.

Scarlet Fever
Symptoms: Vomiting, high fever, rash on neck and face and then spreading over the body.
Treatment: No effective medicine; cold water enemas, quinine, bed rest.

Pneumonia
Symptoms: Pained breathing, cough, weakness, high fever.
Treatment: Tonics; bed rest, bleeding with leeches to relieve chest pain; opium or morphine to induce sleep.

Statistics for the same five years for Michigan.

	Total	Average Per Year	Rate Per 100,000
Consumption	5,822	1,164	106
Typhoid Fever	2,088	417	38
Scarlet Fever	1,949	390	35.5
Pneumonia	1,916	383	34.8
Dysentery	1,351	270	24.5

Population estimate—1,100,000

The exhibits about Causes of Death are among the many authentic displays in the MSMS Healthmobile which is sponsored each week by a different county medical society across the state.

SPECIAL ARTICLE

Adverse Reactions to Drugs

Report Them to New Registry

A registry on adverse reactions has been established by the Council on Drugs of the AMA. The Council has prepared several mailing pieces relating to this subject, and the following material has been extracted from one of those pieces:

The following reaction chart has been complied from suspected cases reported to the Registry on Adverse Reactions. In addition, we have included data culled from current literature. The list is necessaril limited, and further information is available upon request. *It must be stressed that this is not a condemnation of any particular drug or chemical.* Rather, i is a means of alerting the physician to the potential o drug or chemical reaction. It may serve also as a reminder in differential diagnosis when drugs or chemicals often are overlooked.

This is another of the outstanding services rendere by the AMA to the public through practicing physicians. From time to time, we hope to publish additional information from this source. Physicians ar encouraged to report unpublished data on serious unusual, or unexpected reactions, even though suc observations may be based only on suspicion or circumstantial evidence.

Additional information and report forms are available from the AMA Registry on Adverse Reactions Council on Drugs, American Medical Association 535 North Dearborn Street, Chicago, Illinois 60610

Aplastic Anemia
- Benzene and other organic solvents
- Chloramphenicol
- Diphenylhydantoin
- Insecticides
- Mephenytoin
- Sulfonamides
- Trimethadione

Auditory Dysfunction
- Chloroquine
- Kanamycin
- Quinine
- Streptomycin
- Viomycin

Collagen Disorders
- Diphenylhydantoin
- Griseofulvin
- Hydralazine
- Isoniazid
- Sulfonamides

Jaundice (Cholestatic)
- Aminosalicylic Acid (PAS)
- Chlorpropamide
- Ectylurea
- Erythromycin Estolate
- Imipramine
- Methimazole
- Methyltestosterone
- Norethindrone
- Norethynodrel
- Phenothiazines
- Triacetyloleandomycin

Jaundice (Hepatocellular)
- Aminosalicylic Acid
- Diphenylhydantoin
- Halothane
- Iproniazid and Other Hydrazines
- MAO Inhibitors

Leukopenia
- Chloramphenicol
- Chlorothiazide
- Chlorpropamide
- Diphenylhydantoin
- Dipyrone
- Imipramine
- Penicillamine
- Phenothiazines
- Phenylbutazone
- Sulfonamides

Parkinsonism
- Imipramine
- Mecamylamine
- Phenothiazines
- Rauwolfia Alkaloids

Peripheral Neuropathy
- Colistimethate Sodium
- Ethionamide
- Ethoxzolamide
- Furaltadone
- Isoniazid
- Methimazole
- Nitrofurantoin
- Nitrofurazone
- Streptomycin
- Sulfonamides

Photosensitivity
- Chlorothiazide
- Griseofulvin
- Nalidixic Acid
- Phenothiazines
- Sulfonamides
- Tetracyclines

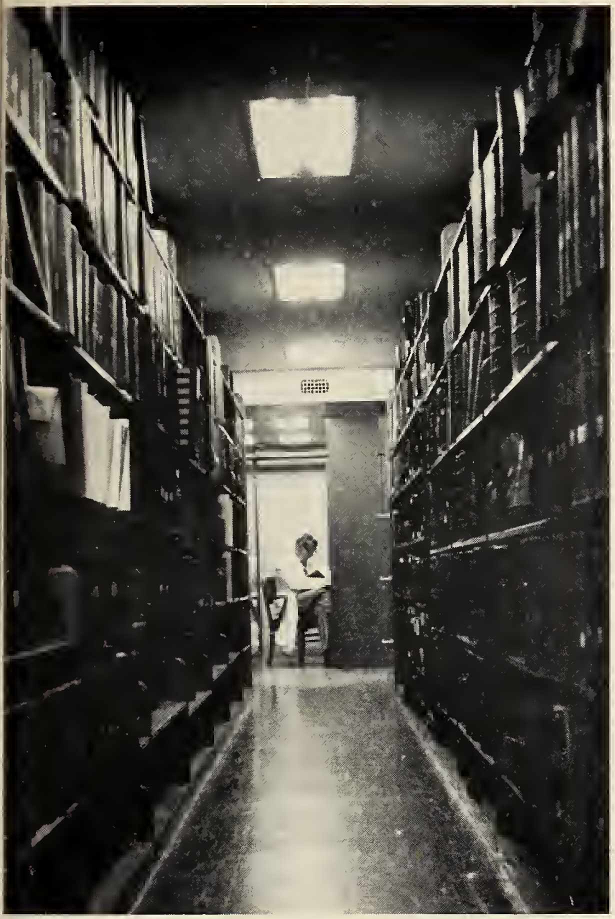
Psychoses
- Carbarsone
- Chloroquine
- Isoniazid
- Quinacrine
- Sulfonamides

Toxic Nephropathy
- Colistimethate Sodium
- Kanamycin
- Phenacetin
- Phenindione
- Phenylbutazone
- Probenecid
- Salicylates
- Tetracyclines

"Medicine in Our Changing World"

Theme for MSMS Annual Session, Grand Rapids,

September 27-28-29-30



List Books By MD Profs Of U-M, WSU

The cover motif of "books" is used to call attention of the medical profession and the general public to the many medical books that have been written by faculty members of the medical schools at the University of Michigan and Wayne State University.

Thanks to the cooperation of the medical school librarians and researchers, these lists were obtained. The other lists of books by non-faculty physicians in Michigan is almost impossible to compile.

The lists also would be longer and more complete if we included those written by members of such allied college departments as nursing, pharmacy, etc.

And there are many MSMS members who have written or are writing fiction books, often with a medical history flavor.

Efforts will be made to print such a list again in several years; and then books may be included that were authored by the medical faculty members at Michigan State University.

The following lists are printed to give recognition to these men . . . and we express the same congratulations to those whose names may be inadvertently omitted.

University of Michigan Medical School Faculty

Group I. Books Published Within the Last Five Years

Allen, Arthur W. and Barrows, W., ed.
  Abdominal surgery. N. Y., Hoeber, 1961.
Barrows, W. See Allen, Arthur W.
Campbell, Colin.
  Anemias in pregnancy; an instructional program. Ann Arbor, U. of Mich. Pr., 1964.
Child, Charles G., III and Coon, William W.
  The Liver and portal hypertension. Philadelphia, Saunders, 1964.
Christensen, Halvor N.
  Body fluid and the acid-base balance. Philadelphia, Saunders, 1964.
  Body fluids and their neutrality. Rev. ed. N. Y., Oxford U. Pr., 1963.
  Biological transport. N. Y., Benjamin, 1962.
  pH and dissociation: a learning program. 2d ed. Philadelphia, Saunders, 1964.
Coon, William W. See Child, Charles G., III.
Crosby, Elizabeth C., joint author with Ariëns Kappers, Cornelius U.
  The Comparative anatomy of the nervous system of vertebrates, including man. N. Y., Hafner, 1960. 3 vols.
  Correlative anatomy of the nervous system (with T. Humphrey and E. Lauer). N. Y., Macmillan, 1962.
Davenport, Horace W.
  ABC of acid-base chemistry. 4th ed. Chicago, U. of Chicago Pr., 1958.
  Physiology of the digestive tract. Chicago, Year Book, 1961.
Dingman, Reed O. and Natvig, Paul.
  Surgery of facial fractures. Philadelphia, Saunders, 1964.
Finch, Stuart M.
  Fundamentals of child psychiatry. N. Y., Norton, 1960.
  Introduction to psychiatry. 3d ed. N. Y., Norton, 1964.
French, Arthur B.
  Low gluten diet with tested recipies. 3d ed. Ann Arbor, 1964.
Hodges, Fred J., Lampe, Isadore and Holt, John F.
  Radiology for medical students. 4th ed. Chicago, Year Book, 1965.
Holmes, Donald J.
  The Adolescent in psychotherapy. Boston, Little, Brown, 1964.
Holt, John F. See Hodges, Fred J.
Judge, Richard D. and Zuidema, G., ed.
  Physical diagnosis: a physiologic approach. Boston, Little, Brown, 1963.
Kahn, Raymond H. See Merchant, Donald J. (Handbook . . .)
Kooth, Robert S., ed.
  Somatic cell genetics. Fourth Josiah Macy Conference on genetics, 1962. Ann Arbor, Univ. of Mich. Pr., 1964.
Lampe, Isadore. See Hodges, Fred J.
Lauer, Edward W. See Crosby, Elizabeth C.
Lowrey, George H. See Watson, Ernest H.
Merchant, Donald J., Murphy, W., and Kahn, R.
  Handbook of cell and organ culture. 2d ed. Minneapolis, Burgess, 1964.
Murphy, William H. See Merchant, Donald J.
Neel, James V.
  Changing prespectives on the genetic effects of radiation. Springfield, Ill., Thomas, 1963.

FACULTY AUTHORS/continued

The Effect of exposure to the atomic bombs on pregnancy termination in Hiroshima and Nagasaki. Atomic Bomb Casualty Commission, Hiroshima, Japan. Wash., 1956.
Editor: Symposium on contributions of genetics to epidemiologic studies of chronic diseases, Ann Arbor, Michigan, 1963. (Proceedings) Wash., U.S. Dept. HEW, 1965.
See also: Schull, William J.

Schull, William J.
The Effects of inbreeding on Japanese children. (with J. V. Neel) N. Y., Harper, 1965.
Editor: Mutations. Second Josiah Macy Conference on genetics, Princeton, N. J., 1960. Ann Arbor, U. of Mich. Pr., 1962.
Editor: Genetic selection in man. Third Josiah Macy Conference on genetics, 1961. Ann Arbor, U. of Mich. Pr., 1963.

Watson, Ernest H. and Lowrey, George H.
Growth and development of children. 4th ed. Chicago, Year Book, 1962.

Willson, J. Robert
Atlas of obstetric technique. St. Louis, Mosby, 1961.
Management of obstetric difficulties. 6th ed. St. Louis, Mosby, 1963.
Obstetrics and gynecology. 2d ed. St. Louis, Mosby, 1963.

Woodburne, Russell T.
Essentials of human anatomy. 3d ed. N. Y., Oxford U. Pr., 1965.
Guide to dissection in gross anatomy. Rev. ed. Oxford U. Pr., 1961.

Zuidema, George D. See Judge, Richard D.

Group II. Important Earlier Contributions

Alexander, John.
The Collapse therapy of pulmonary tuberculosis. Springfield, Ill., Thomas, 1937.

Behrman, Samuel J. and Gosling, John R. G.
Fundamentals of gynecology. N. Y., Oxford U. Pr., 1959.

Beierwaltes, William H., Johnson, Philip C. and Solari, Arthur J.
Clinical use of radioisotopes. Philadelphia, Saunders, 1957.

Blain, Alexander III See Coller, F. A.

Block, Walter D. and Van Goor, Kornelius.
Metabolism, pharmacology, and therapeutic uses of gold compound. Springfield, Ill., Thomas, 1956.

Coller, Frederick A.
Cancer of the colon and rectum. N. Y., American Cancer Society, 1956.
Indications for and results of splenectomy. Springfield, Ill., Thomas (1950) (with Blain, Alexander III and Andrews, Gould)

DeJong, Russell N.
The Neurologic examination, incorporating the fundamentals of neuroanatomy and neurophysiology. 2d ed. N. Y., Hoeber-Harper, 1958.

Francis, Thomas, Jr.
Michigan. University. Poliomyelitis Vaccine Evaluation Center. Evaluation of the 1954 field trial of poliomyelitis vaccine; final report. Ann Arbor, 1957.

Gosling, John R. G. See Behrman, Samuel J.

Hoobler, Sibley W. Hypertension disease; diagnosis and treatment. N. Y., Hoeber, 1959.

Johnson, Philip C. See Beierwaltes, William H.

Kahn, Edgar A. and others.
Correlative neurosurgery. Springfield, Ill., Thomas, 1955.

Kahn, Reuben L.
Serology with lipid antigen, with special reference to Kahn and universal reactions. Baltimore, Williams & Wilkins, 1950.
Technique of the standard Kahn test and of special Kahn procedures. Rev. ed. Ann Arbor, Mich., U. of Mich., 1946.
Tissue immunity. Springfield, Ill., Thomas, 1936.

Lawrence, Merle (with Ernest G. Wever)
Physiological acoustics. Princeton, Princeton U. Pr., 1954.

Lovell, Robert G. See Sheldon, John.

Mathews, Kenneth P. See Sheldon, John.

Patten, Bradley Merrill
Early embryology of the chick. 4th ed. N. Y., McGraw Hill, 1951.
Embryology of the pig. 3d ed. N. Y., McGraw-Hill, 1948
Foundations of embryology. 2d ed. N. Y., Blakiston, 1953

Riley, Gardner M.
Essentials of gynecologic endocrinology. Ann Arbor. Caduceus Pr., 1948.
Gynecologic endocrinology. N. Y., Hoeber-Harper, 1959

Sheldon, John M., Lovell, Robert G. and Mathews, Kenneth P.
A Manual of clinical allergy. Philadelphia, Saunders 1953.

Solari, Arthur J. See Beierwaltes, William H.

Sturgis, Cyrus C.
Diseases of the blood. N. Y., National Medical Book Co. Inc., 1937.
Hematology. 2d ed. Springfield, Ill., Thomas (1955)
Hypersplenism; a clinical evaluation. Springfield, Ill. Thomas, 1953.

Warthin, Aldred S.
The Creed of a biologist. N. Y., Hoeber, 1930.
Old age, the major involution; the physiology and pathology of the aging process. N. Y., Hoeber, 1929.
The Physician of the dance of death. N. Y., Hoeber 1931.
Practical pathology; a manual of autopsy and laboratory technique for students and physicians. 2d ed. Ann Arbor, G. Wahr, 1911.

Works by G. Carl Huber, Victor C. Vaughan and Frederick G. Novy could also be included in this list, and there are probably others equally important if additional names are wanted.

Group III. Contributions

Alpern, Mathew.
Movements of the eyes, Chap. 1-7; Accommodation, Chap. 8 *in* Davson, Hugh, ed. The Eye, v. 3. N. Y., Academic, 1962.

DeJong, Russell N.
Case taking and the neurologic examination *in* Clinical Neurology, ed. by A. B. Baker, 2d ed., v. 1. N. Y., Hoeber, 1962.

Feller, Irving
A Second look at adrenal cortical function in burn stress *in* Research in Burns, Publ. no. 9. Wash., D. C., Amer. Inst. of Biol. Sci., 1962.

Lapides, Jack
Urology *in* Surgery, principles and practice. Philadelphia, Lippincott, 1961.

Wayne State University Medical School Faculty

Group I. Books Published within the Last Five Years

Anderson, G. F.: Experimental Pharmacology Laboratory Manual. Ann Arbor: Edwards Bros., 1965.

Bates, J. E., and Zawadski, E. S.: Criminal Abortion—A Study in Medical Sociology. Springfield: Charles C Thomas, 1964.

Beckett, P. G. S.: Adolescents Out of Step: Their Treatment in a Psychiatric Hospital. Lafayette Clinic Monographs in Psychiatry, No. 2, G. Tendler, ed. Detroit: W.S.U. Press, 1965; Toronto, Canada: Ambassador Books, 1965.

Brooks, S. C., Godefroi, V. S., and Simpson, W. L.: Metabolic Activity of Isolated Skin Components—II. D. M. Pillsbury, C. S. Livingood, eds. New York: Excerpts Medica Foundation, 1963.

Daves, L., and Loechel, W. E.: The Interpretation of Tomograms of the Head. Springfield: Charles C Thomas, 1962.

Dunham, H. W.: The Culture of the State Mental Hospital. Detroit: W.S.U. Press, 1960. (with S. K. Weinberg)

Mental Disorders in Urban Areas, Phoenix Edition (paperback); Chicago: University of Chicago Press, 1965. 3rd printing.

Community and Schizophrenia: An Epidemiological Analysis. Lafayette Clinic Monographs in Psychiatry, No. 1. B. Woodward, ed. Detroit: W.S.U. Press, 1965; Toronto, Canada: Ambassador Books, 1965.

Foà, J. P., and Galansino, G.: Glucagon: Chemistry and Function in Health and Disease. Springfield: Charles C Thomas, 1962.

Foà, J. P., Grillo, T. A. I., Okuno, G., Guidotti, G., and Price, S.: Studies on the Ontogenesis of the Pancreas. Wenner-Gren Symposia. Oxford: Pergamon Press, 1964.

Gardner, E., Gray, D. J., and O'Rahilly, R.: Anatomy. Philadelphia: W. B. Saunders, 1960; 2nd ed., 1963.

Gardner, E.: Fundamentals of Neurology, 4th ed. Philadelphia: W. B. Saunders, 1963.

Gottlieb, J. S., and Tourney, G.: Scientific Papers and Discussions. A.P.A. District Branch Publication 1, 1960.

Gurdjian, E. S., Gardner, E. D., Hardy, W. G., Lindner, D. W., Thomas, L. M., and Webster, J. E.: Operative Neurosurgery, ed. 2. Baltimore: Williams & Wilkins, 1964.

Gurdjian, E. S., and Webster, J. E.: Operative Neurosurgery. 1962.

Kurtzman, R. S.: Principles of Cardiac Roentgenology. New York: Harper & Row, 1966. (In press)

Lasker, G. W.: The Evolution of Man: A Brief Introduction to Physical Anthropology. New York: Holt, Rinehart, and Winston, 1961.

Human Evolution: Physical Anthropology and the Origin of Man. New York: Holt, Reinhart, and Winston, 1963.

Levitt, M.: Freud and Dewey on the Nature of Man. New York: Philosophical Library, 1960.

Levitt, M., Meyer, R., Falick, M., and Rubenstein, B. O.: Essentials of Pediatric Psychiatry. New York: Appleton-Century-Crofts, 1962.

Lloyd, J. R.: Contributions to Pediatric Surgery. Benson et al., eds. Chicago: Year Book Medical Publishers, 1962.

Loeb, C., and Meyer, J. S.: Strokes Due to Vertebro-Basilar Disease. Springfield: Charles C Thomas, 1964.

Loechel, W. E.: Medical Illustration:
A Guide for the Doctor-Author and Exhibitor. Springfield: Charles C Thomas, 1964.

Mizeres, N. J., and Gardner, E.: Methods of Dissection. Philadelphia and London: W. B. Saunders, 1963.

Orten, J. M., and Kleiner, I. S.: Human Biochemistry. St. Louis: C. V. Mosby, ed. 6, 1962; ed. 7, 1966 (in press).

Proctor, L. R.: Chronic Progressive Deafness: Resumé of Research on Otolaryngology, 1952-59. Detroit: W.S.U. Press, 1964.

Rights, F. L., Weiner, L. M., Jeffries, C. D., and Berk, R.: Medical Microbiology Laboratory Manual. Ann Arbor: Edwards Bros., 1963.

Rubin, E. Z., Simson, C. B., and Betwee, M. C.: Emotionally Handicapped Children and the Elementary School. Lafayette Clinic Monographs in Psychiatry, No. 3. Detroit: W.S.U. Press, 1956. (In press)

Seegers, W. H.: Prothrombin. Commonwealth Fund. Cambridge: Harvard University Press, 1962.

Shepard, R. S.: Physiology Laboratory Manual. Ann Arbor: Edwards Bros., 1962.

Triantaphyllopoulos, D. C.: Progress in Coagulation. F. Koller, ed. Stuttgart: Friedrick-Karl Schattauer-Verlag, 1962.

Vorwald, A. J.: Graphitosis. Eastman-Kodak Co., Monograph, 1956. (In press)

Waldbott, G. L.: A Struggle With Titans. New York: Carleton Press, 1965.

II. Some Earlier Books

Dorsey, J. M., and Seegers, W. H.: Living Consciously: The Science of Self. Detroit: W.S.U. Press, 1959.

Gardner, E.: Fundamentals of Neurology, 3rd Ed. Philadelphia: W. B. Saunders, 1958.

Gurdjian, E. S., and Webster, J. E.: Head Injury: Mechanism, Diagnosis and Management. Boston: Little, Brown, 1958.

Levitt, M.: Readings in Psychoanalytic Psychology. New York: Appleton-Century-Crofts, 1959.

Schwartz, L., Tulapian, L., and Birmingham, D. J.: Occupational Diseases of the Skin, ed. 3. Philadelphia: Lea & Febiger, 1957.

Sugar, H. S.: The Glaucomas, 2nd ed. New York: P. Hoeber, 1957.

(Afraid we are rather low on records of publications prior to 1961. If you need more, however, we can probably get hold of them via curriculum vitaes.)

III. Contributions

Bing, R. J., Wendt, V. E., Balcon, R., and Ribeilima, J.: Circulatory changes following experimental myocardial infarction.

Birmingham, D. J.: Clinical Aspects of Cutaneous Irritation and Sensitization. In Toxicology and Applied Pharmacology, Suppl. 2. New York: Academic Press, 1965.

Evans, T. N.: Benign Diseases of the Uterine Body. In Gynecology—Principles and Practice. R. A. Kimbrough, ed. Philadelphia: J. B. Lippincott, 1965.

Frohman, C. E., Beckett, P. G. S., and Gottlieb, J. S.: Control of the plasma factor in schizophrenia. In Recent Advances in Biological Psychiatry, VII. J. Wortis, ed. New York: Plenum Press, 1965.

Goodman, M.: Problems of Primate Systematics Attacked by the Serological Study of Proteins. In Taxonomic Biochemistry, Physiology and Serology. C. Leone, ed. New York: Ronald Press, 1964.

Henry, R. L.: Methods for the *in vivo* study of thrombosis. *Also* Study of thrombosed blood vessels by quick-freezing and freeze-substitution fixation. In Blood Coagulation, Hemorrhage and Thrombosis. L. M. Tocantins and L. A. Kazal, eds. New York: Grune & Stratton, 1964.

Krabbenhoft, K. L.: Diagnostic use of ionizing radiations as applied externally to the human body. In The Science of Ionizing Radiation. Springfield: Charles C Thomas, 1965.

Lasker, G. W.: Studies in Racial Isolates. In Methods and Goals in Human Behavior Genetics. S. Vandenberg, ed. New York: Academic Press, 1965.

Levitt, M., and Rubenstein, B.: Countertransference. In Child Psychotherapy. M. R. Haworth ed. New York: Basic Books, 1964.

Lowinger, P., and Dobie, S.: An evaluation of the role of the psychiatrist's personality and the interview. In Science and Psychoanalysis. New York: Grune & Stratton, 1964.

WAYNE STATE UNIVERSITY
1868

FACULTY AUTHORS/continued

Meyer, J. S.: Stroke: Report of the Subcommittee and Recommendations to the President. In A National Program to Conquer Heart Disease, Cancer, and Stroke. Washington, D. C.: U.S. Government Printing Office, 1965.

Orten, J. M.: Biochemical Aspects of Zinc Metabolism. In Zinc Metabolism. A. S. Prasad, ed. Springfield: Charles C Thomas, 1966.

Pinkus, H.: Die Makroskopische Anatomie der Haut. In Handbuch der Haut—u. Geschlechtskrankheiten. A. Marchionini, ed. Germany: Springer-Verlag, 1964.

Read, R. C.: Observations on the etiology of Spingelian hernia. In Hernia. Nyhus and Harkins, eds. Philadelphia: Lippincott, 1964.

Seegers, W. H.: Experiments Relating the Activation of Purified Prothrombin to Surfaces. In Biophysical Mechanisms in Vascular Homeostasis and Intravascular Thrombosis. P. N. Sawyer, ed. New York: Appleton-Century-Crofts, 1965.

Zak, B.: Total and Free Cholesterol. In Standard Methods of Clinical Chemistry, Vol. 5. New York: Academic Press, 1965.

Book Review

UNSAFE AT ANY SPEED. By Ralph Nader. Price $5.95. Pp 365. Grossman, New York, 1965.

The role of the auto industry in the shameful loss of life on our roadways is the subject of this recently released book by Ralph Nader, a practicing attorney from Connecticut. This well-organized volume is a long overdue treatise on the role of the automobile in highway slaughter. Mr. Nader names specific cars and the men who made them unsafe. He pulls no punches from any of this country's car makers, and his candor in describing the dangerous defects of the "Sporty Corvair" in the first chapter will be very enlightening as well as frightening to thousands of Corvair owners. Chapter two bears the title "Disaster Deferred: Studies in Automotive Time Bombs" and this story will alarm owners of a certain model Buick as well as particular Ford and Chrysler products.

The design and construction features which make a vehicle more crashworthy should not be offered as optional items but should be standard equipment. Mr. Nader points out how no cost is spared in making frequent styling changes, yet the flag of too much additional expense is waved when the suggestion of standard safety items is made.

Some readers will be shocked when the author criticizes such revered organizations as the National Safety Council, the AAA and the President's Committee for Traffic Safety. He reveals how these groups help take the onus off the auto industry for the slaughter on our highways.

"Unsafe at Any Speed" should be read by all who own and ride in automobiles.

—P. W. Gikas, M.D.
Ann Arbor

From the Mailbag

Just a short note to thank the Michigan State Medical Society for your excellent inter-professional cooperation in publicizing the Poison Antidote Kit program which the MSPA launched last month.

The article in the March journal, I am sure, assisted greatly in advising the physician members of the health team of the dangers of accidental poisonings and of the proper use of the poison antidotes.

Thank you again for your excellent cooperation.

Sincerely,
Donald A. Dee, R.Ph.
Field Secretary
Michigan State Pharmaceutical Association

(Editor's Note: MSMS President Leader wrote to each Michigan Medicine advertiser recently, expressing appreciation. Following are excerpts of two replies.)

Dear Doctor Leader:

Thank you for your recent letter voicing your appreciation for our advertising in Michigan Medicine.

We will certainly be continuing our advertising program, and your offer to help in any way is greatly appreciated.

We at Geigy hope that all our good friends in the medical profession in Michigan have a good 1966.

Sincerely,
C. B. William Howell, *President*
Geigy Pharmaceuticals
Ardsley, New York

Dear Doctor Leader:

Thank you so much for the thoughtful letter I received recently about Pitman-Moore advertising during 1965 in Michigan Medicine. Like you, I am impressed by the potential service to pharmaceutical companies offered by state medical journals, and I am making a serious effort to establish the fact that this is an effective advertising medium for Pitman-Moore.

Your representative at the State Medical Journal Advertising Bureau, Monte Brown and John Murphy, have encouraged us to make greater and, we hope, more effective use of this medium. During the past year our use of state journals was largely on an experimental basis—as it must be again in 1966.

Best wishes to you and your organization.

Sincerely yours,
John Gallaway, *Advertising Manager*
Pitman-Moore
Indianapolis, Indiana

lans Revealed to Add 149 Students by '69

MEDICAL EDUCATION TO BE COORDINATED BY STATE BOARD

This letter from the Deans of Medicine in Michigan to State Board of Education Member Leon Fill, Chairman of the State Board's Subcommittee on Medical Education, is printed here in full, because it describes plans to accept 149 new prospective doctors into the three existing schools by 1969.

The role of the State Board of Education in the field of higher education is spelled out in the new State Constitution. State Attorney General Kelley rendered an opinion on October 5, 1965 which in part states that:

". . . it is the opinion of the Attorney General that by means of Article VIII, Section 3, the people have conferred constitutional power upon the State Board of Education to advise and recommended the establishment of a new state college or university. The Legislature is without power to enact a statute establishing such a college or university without the prior determination, advice and recommendation by the State Board of Education."

---

octor Leon Fill
hairman, Subcommittee on
Medical Education
ate of Michigan
ate Board of Education
nsing, Michigan 48902

ear Doctor Fill:

The State Board of Education, in concern for the proper evaluation health care manpower needs in e State of Michigan, has appoint- a Citizens' Committee on Educa- n for Health Care. The Board s charged this committee with the sk of identifying Michigan's broad alth care needs and recommend- g an appropriate health care edu- tion program.

The three medical schools in Mich- an—the University of Michigan, ayne State University, and Mich- an State University—have plans d commitments for increasing the mber of physicians. These plans ve been developed through the co- dinated efforts of the medical hools. In order to keep the State oard of Education and its Commit- e informed, in accordance with the quest expressed in its resolution of ovember, 1965, the medical schools e herewith submitting a brief ac- unt of their plans.

Beginning in the fall of 1966, ichigan State University will take n entering class of twenty-five med- al students. This number will in- ease to at least sixty-four when the ppropriate buildings are completed d operating funds become avail- ble. Application has been made for atching Federal funds and the date f completion of construction is es- mated to be 1969.

Beginning in the fall of 1967, the niversity of Michigan will increase s entering medical school class from 00 to 210 students, and Wayne tate University from 125 to 130.

Beginning in the fall of 1969, ayne State University will increase s entering class from 130 to 200 if e necessary operating and con- ruction funds are provided, and if oney for detailed architectural lanning is made available now. The reliminary planning for the teaching building is done, the land has been purchased, and application has been made for matching Federal funds.

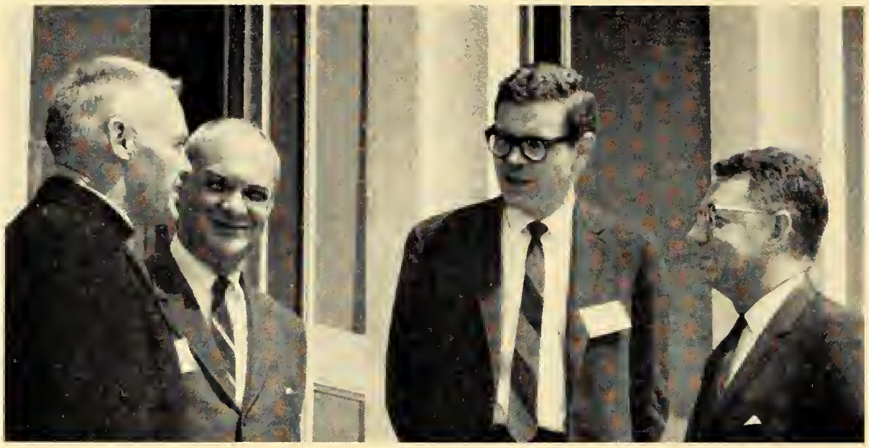
By 1969, therefore, the three medical schools will be admitting at least 149 more medical students than they do now. The increments are seventy-five for Wayne State University (from 125 to 200), sixty-four for Michigan State University (from 0 to 64), and ten for the University of Michigan (from 200 to 210).

The three medical schools have also planned additional cooperative efforts. Given the financial support, the schools could expand their efforts to help hospitals throughout the State strengthen their intern and residency programs, thereby attracting more physicians into the State. Furthermore, the number of excellent hospitals in Detroit makes possible the consideration of still other efforts, including the entrance into the third year at Wayne of students from two-year medical schools, and the use of these hospitals by other four-year schools. Also, by legislative request, the new teaching building at Wayne has been planned for a maximum of 250 entering medical students.

Finally, it must be emphasized that the increasing public demand for readily accessible medical care of the best quality cannot be met simply by graduating more physicians. The efficiency of existing physicians and those of the future must be improved by strengthening and expanding programs in the allied health sciences. Physicians can take care of more patients if they are freed from the necessity of doing tasks that others trained at lesser cost can do. The three universities have substantial paramedical programs underway, and have plans for the improvement and expansion of continuing medical education in order to bring the latest in medical advances to all physicians.

We trust that this information about our plans and commitments which, in our opinion, represent one of the most significant expansions in medical education in the United States, will be of use to the State Board of Education and the Committee on Education for Health Care in their further deliberations.

Sincerely yours,
Ernest Gardner, M.D.
Dean, School of Medicine
Wayne State University
William N. Hubbard, Jr. M.D.
Dean, Medical School
University of Michigan
Andrew D. Hunt, Jr., M.D.
Dean, College of Human Medicine
Michigan State University



Suggestions that physicians and clergymen work closer together, on such matters as sex education and organ transplants, were made by Rev. Wallace Robertson, at right, during the MSMS Workshop on Medicine and Religion, April 13, at the Headquarters. Enjoying a break in the program, left to right, are Rev. Paul McCleave, director of the AMA Department of Medicine and Religion; R. L. Rapport, M.D., Chairman, MSMS Committee on Medicine and Religion; and Robert L. Coons, also of the AMA Department of Medicine and Religion. About 35 members of county medical society committees on medicine and religion joined the MSMS committee for an exchange of information and ideas about projects, relationships, etc.

New Michigan Law

Act No. 397
Public Acts of 1965
Approved July 22, 1965; Effective March 31, 1966

AN ACT regulating the sale or conveyance of the practice of a healing system; to require the reporting of such sale or conveyance and to impose a penalty.

The People of the State of Michigan enact:

338.31 (M.S.A. 14.566 [1])

"Sec. 1. Any person who sells, purchases or assumes the practice of any person licensed to practice medicine or dentistry in this state from the individual or his estate shall notify, within 10 days of sale, purchase or assumption, the state board which licensed or registered the practitioner, of the sale, purchase or assumption."

338.32 (M.S.A. 14.566 [2])

"Sec. 2. Any person violating any provisions of the act shall be deemed to be guilty of a misdemeanor."

(Note: MSMS followed, and supported, this proposal through the Legislature, testifying in favor of it in the Senate and then urging passage by memorandum in the House committee.)

News — To the Point

DETROIT—The new Directory of Michigan's Psychiatric Services, published by the Michigan Society for Mental Health, is available for $2 from the Society, 1528 Woodward Avenue, Detroit 48226.

FERNDALE—The Kingswood Hospital, Ferndale, is now distributing a continuing newsletter called, "Mental Health Information." The publication will contain not only items concerning Kingswood but the general psychiatric profession a well.

Smoking-Health Grant to MHC

The Michigan Health Council East Lansing will receive a $20,9 federal grant to coordinate the pr gram and activities of the Michiga Council on Smoking and Heal from July 1, 1966, to June 30, 196

Prime purpose of the grant will to help Michigan health and educa tional organizations offset the $2 million advertising campaign of ci arette manufacturers aimed at kee ing cigarette sales booming.

Announcement of the grant, whic came in a wire from Congressma Charles E. Chamberlain, said "Plea be informed that a U. S. Publ Health grant of $20,900 has bee awarded you for cancer studies r lated to smoking. Best Wishe Charles E. Chamberlain, Member Congress."

The Michigan State Medical So ciety and 10 other voluntary and off cial health and educational orgar izations concerned with smoking an its relationship to health and diseas will guide the project. These includ representatives of the American Car cer Society, Michigan Heart Associa tion, Michigan Tuberculosis and Re piratory Disease Association, Mich gan Cancer Foundation, Michiga Department of Education, Michiga Department of Public Health, Mich gan Education Association and th Michigan Health Council.

MHA Offers Four Seminars

The Michigan Heart Associatio will sponsor four area-wide seminar on Coronary Intensive Care Unit in Lansing, May 18; Grand Rapid May 19; Flint, May 25; and Mar quette, June 2.

The seminars are designed fo physicians, nurses, hospital adminis trators and board members.

ppel, Others n UP Program, une 17-18

Likely the most ambitious program ver planned, the Upper Peninsula ledical Society Annual Meeting will e held at Iron Mountain, June 17-.

Highlights will include:

- —Address by AMA President Appel, June 18;
- —Comments by MSMS President Leader, and other dignitaries, June 17;
- —Address by Governor Romney, June 17;
- —Address by Homer Stryker, M.D., Kalamazoo, on "Backing Into Business Without Even Trying," at the banquet, June 17;
- —Exhibition of the MSMS Healthmobile;
- —And scientific addresses by such authorities as Doctors Samp, Forester, Boles, Moyer, and others.

W. H. Huron, M.D., Iron Moun- in, president of the Upper Penin- la Medical Society, invites all in- rested MSMS members to partici- te in the excellent program. The ickinson Hotel and the Country lub will provide the setting for the ent.

The scientific program which will gin at 9:30 a.m., June 17, will ver such topics as "Treatment of eukemia and Lymphoma," "Re- nt Advances in Diagnostic X-Ray," Treatment of Epilepsy," "Ear Sur- ry," and others.

Carl Moyer, M.D., formerly of leveland and now of Houghton, ill speak at the luncheon, June 18, "The Wealth of the Upper Pen- sula."

Norman Lindquist, M.D., is Presi- nt-Elect of the Society, and D. J. cobs, M.D., is Secretary.

Reservations for housing should be nt to Donald T. Anderson, M.D., 8 Hamilton Avenue, Kingsford.

IN INDEX...

Further proof that Michigan Medicine is recognized as the outstanding medical publication in the state is the fact that the journal is one of those being scanned each quarter by the new State Library publication, called "Michigan Magazine Index."

James G. Igoe, head of Reader Services for the Michigan State Library, points out that "we are indexing those articles on Michigan or Michigan subjects or topics of interest to Michigan readers which appear in magazines published by Michigan organizations, institutions and agencies."

Medicine-Sports Workshop June 2

Richard C. Schneider, M.D., Ann Arbor, recognized nationally as an authority on the medical aspects of athletics, will speak at the "MSMS Conference on Medical Aspects of High School Sports" at Ann Arbor, June 2.

The meeting previously had been announced for May 19, but was rescheduled for the later date.

The new MSMS Committee on Medical Aspects of Organized Athletics will sponsor the one-day seminar at the U-M Medical Center.

Each county medical society is urged to send two or more representatives to the conference. The workshop will suggest ways in which county societies may conduct conferences for physicians and coaches.

A program has been sent to every MSMS member.

Call MDPAC Workshop in Detroit, June 5

As a forerunner to the medical profession's participation in the 1966 elections, the Michigan Doctors Political Action Committee will sponsor a statewide workshop in Detroit, June 5.

Each county medical society has been urged to send representatives in ratio to the number of delegates they have.

Wyman C. C. Cole, Jr., M.D., Detroit MDPAC chairman, points out that "you will want to take advantage of this excellent opportunity to further your county society's knowledge and understanding of practical politics here in Michigan, and nationally."

County representatives will be the guests of MDPAC for the luncheon. The program at the Sheraton- Cadillac Hotel is planned from 10 a.m. to 5 p.m. Speakers will include members of the U. S. Congress and the Michigan legislature, according to Chairman Cole.

Louis F. Hayes, M.D., Gaylord, Vice-Speaker of the MSMS House of Delegates, and a member of the MDPAC Board of Directors, is the workshop chairman.

(See related article on Page 404.)

Wellman, Payne Join MMS Board

Two physicians were recently elected to the Board of Directors of Michigan Medical Service. They are John M. Wellman, M.D., Lansing, surgeon, and Beverly C. Payne, M.D., Ann Arbor, internist.

Both are active in their county medical societies and the MSMS—in addition to other medical organizations.

Continuing Education Center Is Nearing Reality at U-M

Gifts of $750,000 from the Herbert H. and Grace A. Dow Foundation of Midland and of $300,000 from the Harry and Margaret D. Towsley Foundation, of Ann Arbor, were received April 15 by Regents of the University of Michigan. The gifts, together with an earlier grant of $700,000 from the Towsley Foundation, will finance construction of a Continuation Education Center for the Medical Center.

Preliminary plans for the building were also approved by the Regents, as submitted by the architectural firm of Alden B. Dow Associates, Inc. of Midland.

Completion of the new center is expected early in 1968. The new building will provide facilities for the university's extensive program of postgraduate education in medicine and related health sciences.

The postgraduate continuing education center will be located in the Medical Center area, north of the Women's Hospital and fronting on East Hospital Drive.

A two-story structure is planned. The lower level will contain the entrance lobby, administrative offices, eight double guest rooms, and a large display room. Part of the auditorium will extend down into this level.

On the second level will be a 500-seat amphitheater type auditorium, three 63-seat classrooms, one 154-seat amphitheater type classroom, and lounge facilities.

Health Workers Needed

More than 50,000 health jobs in Michigan are going begging, and the number will double by 1975.

John A. Doherty, executive director of the Michigan Health Council, put these facts before 400 Michigan vocational education teachers meeting at Michigan State University. He called for high school and community college training in health fields to help fill the need.

HOMADE
Cafeteria
112 N. BAUM
Michigan State Medical Society
HEALTHMOBILE
Presenting a Century of Service in Medicine

Excellent cooperation has been provided by the several utility powe firms across the state as the Healthmobile moves each week from town t town. The utility crews hook up the power, and firms provide the necessary electricity—at no charge to MSMS. Such public service support i greatly appreciated by MSMS officials.

Healthmobile in Wisconsin, Then Across Upper Peninsula

The accomplishments of Michigan physicians during the past century—dramatically displayed in the MSMS Healthmobile—will be studied by Wisconsin physicians during May.

The Healthmobile has been invited by the State Medical Society of Wisconsin to be on display at their 125th Anniversary at La Crosse. The Wisconsin Society will cover the costs of transporting the handsome trailer.

The May and June calendars are busy ones for the Healthmobile, our health-museum-on-wheels that is popular with children, teachers, parents.

The Healthmobile will be in Muskegon for the big West Michigan Health Fair sponsored there by the Muskegon County Medical Society, May 2-7.

From Wisconsin, the Healthmobile will move into the Upper Peninsula to open at Ironwood, May 13-18; t Houghton, May 18-24; to Marquette, May 25-June 1; then Escanaba, June 1-8; and Menominee June 8-15.

The Upper Peninsula route wa developed deliberately so the MSM Healthmobile could be shown a Iron Mountain, June 15-20, durin the annual meeting of the Uppe Peninsula Medical Society ther June 17-18.

After visiting the Soo, June 20-27 the Healthmobile will zig-zag acros the northern part of the Lower Peninsula and then appear at many o the county fairs during the summer

In each town, the County Medica Society and its Auxiliary sponsor th Healthmobile, with excellent cooperation from city officials, merchants, schools, newspapers, radi and television stations, etc.

BLUES AND MEDICARE

By W. H. Huron, M.D.
Iron Mountain

The designation of Blue Shield as the fiscal agent of Title 19 in Michigan is a tribute to those who worked so hard during the 30's and 40's to establish an organization (over which the doctors had some controls) to help people prepay their medical costs.

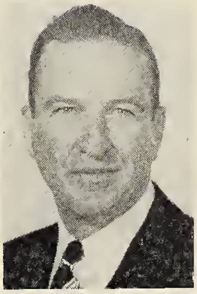
Let us hope and anticipate that these controls will be used equitably and judiciously for the doctors, their patients and our government.

"The bigger the place becomes the more does responsibility branch out; divided and subdivided, responsibilities become the charge of numberless petty despots who insist on having their separate say."—From Affairs at State, Henry S. Villard.

LAW DAY U S A

By John S. Clark, President
State Bar of Michigan

On Sunday, May 1, our nation celebrated Law Day U.S.A., with the theme "Respect the Law—It Respects You."



History shows that many civilizations have risen to grandeur, then vanished from the earth. The life span of civilization has exceeded that of nations, and eminent historians say the average cycle of the history of a nation has been 200 years. During this period not only do nations rise and fall, but their people pass from bondage to freedom to bondage. Man's struggle for freedom against tyranny has produced our great nation—a government under law, and a beacon light for oppressed peoples of the world who seek freedom, justice and equality.

Yet today world order is in peril—even we have a wave of rebellion against law and order.

Whether it is a traffic violation, a scuffle at a drive-in, cheating a customer, the end result of disrespect for human rights and law is chaos and trouble.

Laws curb the evildoer, but they also give reasonable regulation to the lives of all people. Without law, physical safety, property rights and the right to pursue our individual destinies would cease to exist.

No citizen can be only a spectator in our fight to preserve law and order. By respecting and obeying all laws, by aiding public officials in the prevention of crime, by bearing witness against crime, by serving on juries when called—we can strengthen and maintain freedom. The great individual rights we cherish and rely upon carry with them individual responsibilities. The citizen who claims rights but refuses to accept and carry out these responsibilities, weakens our nation—invites the operation of the 200-year cycle and forfeiture of our freedoms.

PLEA FOR BREVITY

By George H. Lowrey, M.D.
Scientific Editor

It usually is the prerogative of a new editor to present to a board in control, in this instance, the Publication Committee, some new policies. This has been done and this is the first opportunity that has been available to discuss these with the members of the Michigan State Medical Society. Actually, only one new idea is proposed at this time and your reaction to it is urgently requested.

In the future, more priority will be given to short and informative manuscripts than has been true in the past. There will be no reduction in the number of pages devoted to scientific material; in fact, we will increase it as the advertising picture continues to improve.

In the short time that I have helped the Publication Committee review manuscripts submitted for Michigan Medicine, I have been impressed with the length of most of them. This means that only a small number can be published. Our available space is not unlimited. Many worthwhile articles are either not published or appear in some other journal.

The length of many original articles could easily be reduced. Let us face facts: We all have a tendency to verbosity—a trait that may have rubbed off from exposure to our medical school professors. Brevity may not be everything, but we are all aware of the good stories, novels, movies or plays ruined by the author's stretching his material.

References and bibliographies can be reduced in size by selecting one or two recent reviews of a subject. Most physicians are unimpressed with that show of scholarship of an endless list. Five or six references per paper should lead the interested reader to the proper sources and at the same time give an author adequate support for his statements.

Finally, your new editor is firmly convinced that

Flagyl destroys trichomonads
here & here & here & here
No topical treatment can

Flagyl®

brand of
metronidazole

Flagyl eliminates the difficulties and frustrations that have long attended the treatment of trichomonal infection.

These difficulties arose mainly from:

1) the failure of any previously known agent to destroy the protozoan in paravaginal crypts and glands;

2) the failure of any previously known agent to prevent reinfection by eradicating the disease in male consorts.

The introduction of Flagyl removed both of these long-standing deficiencies. Hundreds of published investigations in thousands of patients have confirmed the ability of Flagyl to cure trichomoniasis.

Correctly used, with due attention to repeat courses of treatment for resistant, deep-seated invasion and to the presumption of reinfection from male consorts, Flagyl has repeatedly produced a cure rate of up to 100 per cent in large series of patients.

Nothing cures trichomoniasis like Flagyl.

Dosage and Administration

In *women:* one 250-mg. oral tablet t.i.d. for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When the inserts are used one vaginal insert should be placed high in the vaginal vault each day for ten days, and concurrently two oral tablets should be taken daily.
In *men:* in whom trichomonads have been demonstrated, one 250-mg. oral tablet b.i.d. for ten days.

Contraindications

Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precautions and Side Effects

Complete blood cell counts should be made before and after therapy, especially if a second course is necessary.

Infrequent and minor side effects include: nausea, unpleasant taste, furry tongue, headache, darkened urine, diarrhea, dizziness, dryness of mouth or vagina, skin rash, dysuria, depression, insomnia, edema. Elimination of trichomonads may aggravate moniliasis.

Dosage Forms

Oral–250-mg.tablets/Vaginal–500-mg.inserts

SEARLE

Research in the Service of Medicine

many potential manuscripts are never written because the potential author or authors won't take the time to write, rewrite and edit an exhaustive treatise which he or they think is required by reviewers for journals.

My plea then is to keep those manuscripts coming. Make them informative and be sure you write what you mean. Keep them short, mostly five to six pages double spaced and we, your obedient servants, will do our best to make your MICHIGAN MEDICINE interesting.

ARE WE ON THE SAME WAVE LENGTH?

By Mrs. Rufus H. Reitzel, President,
Woman's Auxiliary to MSMS

A physician's wife should be an active intregal part of the life of the community in which she dwells. The fields in which she should be interested are many, but certainly none is more important than the health field. The joys of living can be ill enjoyed if one's health is impaired.

The time was when women were frowned upon if they became active in organizations outside the home. They have now learned that to get the things that they feel are good and best for their children and family they must get out and work for them. A physician's wife cannot become a force for good in her community unless she is informed. How better then to study and learn than in the Auxiliary to her husband's county Medical Society.

There is, as it should be, a bond between the doctors' wives in a community. Through association they become strong in their friendships, interested in what is happening in the field of health, willing to participate in community projects, and promote fellowship and good will among their doctor husbands. The above ambitions of these women present a tall order, but it is exactly what they are doing all over the state of Michigan.

To list but a few of the things in which they are active gives one an idea of their capabilities and potential: Mental Health, Health Careers, Legislation, Raising Funds for Medical Schools, Disaster Preparedness, International Health Activities, Medical Student Loan Fund, Safety Councils, Cancer Societies, Rural Health.

There are over 3000 dedicated, earnest, hardworking doctors' wives in our state who belong to the Auxiliary.

Where are the other 3,000 plus who are eligible to belong?

It cannot be that they are not interested and don't care. Perhaps we members have not exerted ourselves to inform these women and let them know that we want and need them. It could also be that their husbands have not encouraged them to become a part of Auxiliary and thereby be a good right arm to the medical societies as well as a force for good health in their community.

Whatever the cause, there is much work the doctors and their wives must do in the recruitment field for Auxiliary.

To return to the topic of being informed, there is a terrific opportunity in visiting the Auxiliary State Convention. The program each year has had many people assembling it, with many and varied topics being presented in a short and interesting way. Being presented this year will be round table discussions, skits, and short talks by authorities in many fields. At the luncheon on September 29, when the women bring their husbands, a well-known speaker will present a topic which is much in the news and about which there is much controversy. To hear this she must be present.

Our State Convention will meet in Grand Rapids on September 27, 28, and 29. Why not give us a chance and bring your wife to this convention as you attend yours at the same time and the same place. It could just be that a spark of interest could be kindled and we might find an active new member.

Each time we have been called upon to assist our county or our State Medical Societies, we, the Auxiliary members, have done it with pride and enthusiasm. In the past years, there have been many such successful times. We now ask you to help us.

Ask your wife why she doesn't belong to Auxiliary if she isn't already a member.

Should she have no specific reason, urge her to become one of us. If her reluctance to join is because of a grievance, please let any member of our Board know of this, and we will do everything in our power to rectify it.

Doctors, we are counting on you to help us with this recruitment problem for we know you will be as interested in cooperating with us as we are with you.

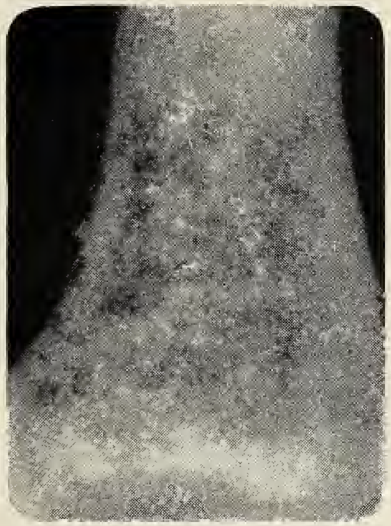
By Patronizing

Our Advertisers

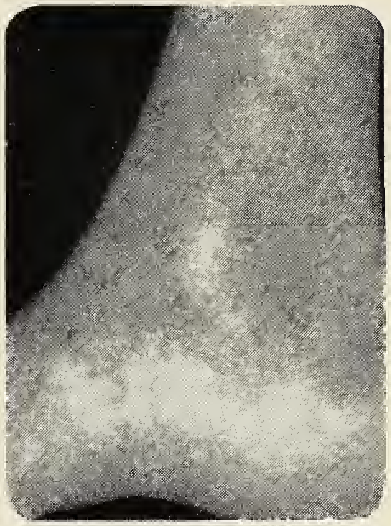
You Help Support

MICHIGAN MEDICINE

eczema: scourge of childhood



R. R., Age 11—Before treatment— atopic eczema of long standing



After treatment—with ARISTOCORT Topical Ointment 0.1% for two weeks

ISTOCORT® Triamcinolone Acetonide Topicals have oved exceptionally effective in the control of various rms of childhood eczema: allergic, atopic, nummular, oriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, e 0.1% concentration is sufficiently potent. The 0.5% ncentration provides enhanced topical activity for tients requiring additional potency for proper relief.

ministration and Dosage: Apply sparingly to the affected ea 3 or 4 times daily. Some cases of psoriasis may be more ectively treated if the 0.1% Cream or Ointment is applied der an occlusive dressing.

ntraindications: Tuberculosis of the skin, herpes simplex, icken pox and vaccinia.

cautions and Side Effects: Do not use in the eyes or in ear (if drum is perforated). A few individuals react un- orably under certain conditions. If side effects are en- untered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Packages: Tubes of 5 Gm. and 15 Gm.; ½ lb. jar.

PHOTOGRAPHS COURTESY OF M. M. NIERMAN, M.D.

Aristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
riamcinolone Acetonide
Also available in foam form and with neomycin.

LEDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York

618-6

GUIDELINES ADOPTED FOR NEGOTIATIONS RE MEDICARE FEES

Guidelines for Medicare negotiations have been developed by the House of Delegates Committee to Determine Monetary Value of Unit of Relative Value Scale and the MSMS Council. These were carried in the March issue of *Medigram* and are repeated here for further understanding.

Following is an extract from the minutes of the House of Delegates Committee to Determine Monetary Value of Unit of Relative Value Scale, meeting of February 28, 1966. The recommendations were reviewed by The Council at its March 16 meeting.

The Council approved each of the recommendations and referred Recommendation Four to the Constitution and Bylaws Committee.

"All indications are that there will be an expanding role of government in responsibility for medical care. The governmental programs, of necessity, must soon offer only one scope of benefits and one standard of care, and ultimately this means only one fee schedule for providers of services. It, therefore, seems essential that any fee schedule be appropriate not only to the patient and responsible agency, but also to the physicians, and with the consideration it is very likely that, in the near future, all physician income may be derived from one such fee schedule. This means that the terms 'usual and customary fee' or 'prevailing fee' necessitate a fee that would be fair to all concerned, and as if every physician's entire income were to be derived from providing services under the single fee schedule. Such a schedule should therefore be one appropriate to the mean or average family income group in Michigan.

"The medical profession can no longer afford to subsidize a part of the population, since the profession will no longer be able to regain this subsidy from any other segment of the population.

"With the foregoing facts and principles in mind, the Committee acted as follows:

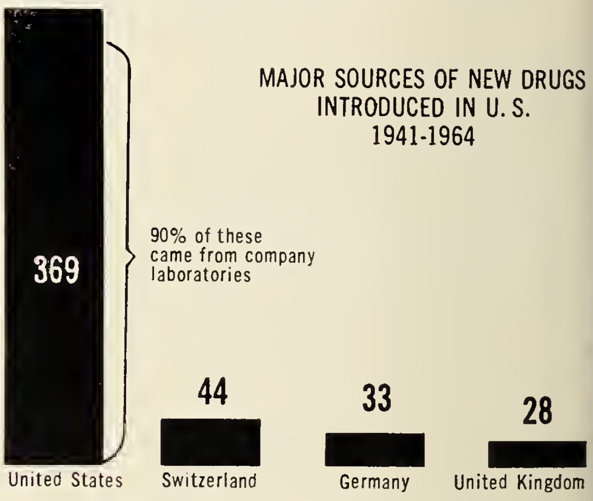
"RECOMMENDATION ONE: That the Michigan State Medical Society adopt a policy that fee schedule(s) for all governmental programs be based on the premise that such schedule(s) be fair, both to the responsible agency and to the physician provider of services and based on the premise that the physician's entire income may become dependent on such a fee schedule(s); carried.

"RECOMMENDATION TWO: That the monetary conversion factor for the 1965 RVS of the Michigan State Medical Society be established at $5.00 (five dollars) for this year; carried.

"RECOMMENDATION THREE: That the monetary conversion factor for any approved RVS of the Michigan State Medical Society be subject to review and redetermination at annual intervals by the Michigan State Medical Society; carried.

"RECOMMENDATION FOUR: That the "House of Delegates Committee to Determine Monetary Value of Unit of Relative Value Scale" be made a *standing* committee of the House of Delegates, and with appointees selected as in the Resolution approved by the MSMS House of Delegates in September, 1965; carried."

AMERICA LEADS IN DRUG RESEARCH

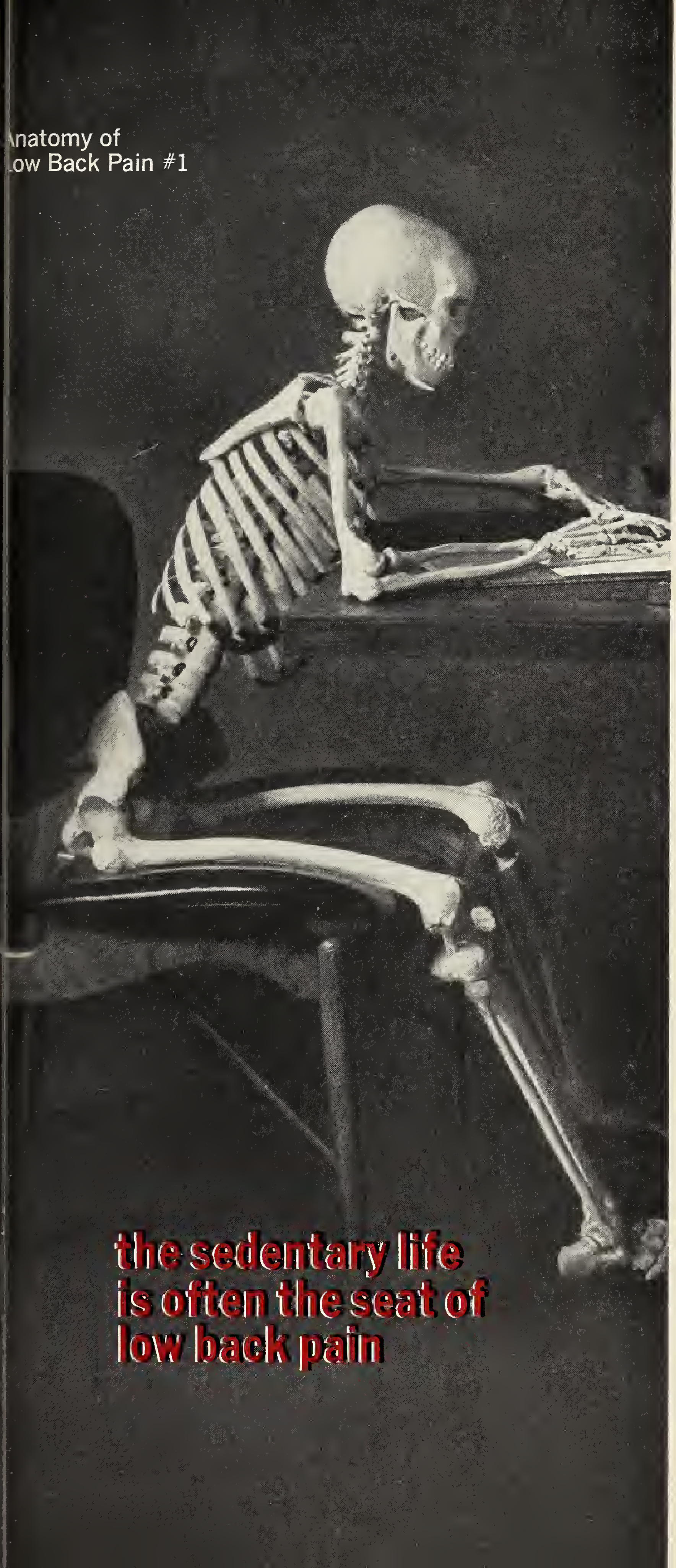


Note: This chart compares the four nations accounting for most drug discoveries. Of 604 new drugs listed in the survey on which the above chart is based, 62 originated in eleven other countries, the national sources for 44 were not identified, 14 were previously known and 10 are credited to more than one country.

TELLS DRUG FACTS

Many facts and figures on the prescription drug industry are contained in the new edition of "Key Facts" published by the Pharmaceutical Manufacturers Association.

Copies are available on request from: Public Information Office, PMA, 1155 15th Street NW, Washington, D. C. 20005.



The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

SOMA®

(CARISOPRODOL)

Wallace Laboratories, Cranbury, N.J.
26S01J

Foundation Surveys Oakland Mentally Ill

The Foundation for Mentally Ill Children, Inc., of Southfield, with the cooperation of the Community Mental Health Services Board, is undertaking a survey of children's services in Oakland County to delineate any gaps and deficiencies in mental health services. A directory of Oakland County is also a hopeful outgrowth of this project.

There are 106 children at the hospital at present, with a waiting list of over 50 children. James W. Johnson, M.D., is director of the Children's Unit, and Charles Hoyt, M.D., is in charge of the Adolescent Unit.

The Foundation recently took a public position against the possible sale of land at the hospital grounds for commercial purposes. A new children's unit (on which construction is scheduled to start in March), future community mental health needs, and contemplated expansion at the hospital are the reasons for opposition to such a proposal.

The Foundation (formerly called the Foundation for Emotionally Disturbed Children) came into being in 1956 in response to the need for children's services at Pontiac State Hospital. The Foundation was organized by James M. McHugh, M.D., then Director of the Children's Program at the Hospital.

WSU JUNIOR HONORED

Stephen F. Winer, a junior at Wayne State University School of Medicine has been awarded a $1,460 fellowship which will enable him to broaden his clinical training by assisting this summer at a rural health center in Vellore, India.

Winer is one of 35 American medical students selected to receive Smith Kline & French Laboratories Foreign Fellowships from the Association of American Medical Colleges.

Winer will assist for 10 weeks at the health center operated at Vellore by the Christian Medical College.

PARTICIPATING HOSPITAL

Mercywood Hospital, Ann Arbor, has been granted a full participating contract with Michigan Hospital Service. The effect of the contract is to assure patients admitted to Mercywood after March 1, 1966, full medical benefit coverage for the costs of psychiatric hospitalization.

List Personnel Changes In State Departments

John K. Altland, M.D., former Associate Director of the State Department of Public Health, began new duties April 1 as Medical Director of the State Social Services Department, a new position. He was appointed by R. Bernard Houston, state social services director.

John Isbister, M.D., formerly Assistant Director of the State Department of Public Health Division of Adult Health, was promoted to Associate Director and Chief of the Bureau of Community Health to succeed Doctor Altland. He was appointed by State Public Health Director Albert E. Heustis, M.D., who also named Roy Manty as Deputy Chief of the Bureau of Community Health and Chief of the Division of Local Health Administration.

Doctor Altland had been with the Department of Health for 20 years, Doctor Isbister for 15 years and Mr. Manty for 16 years.

NEW JOURNAL ISSUED

The group of Michigan hospitals with publications has a new member now—with the publication of the first issue of the *Oakwood Hospital Clinical Journal* by the Oakwood Hospital at Dearborn.

T. G. Todoroff, M.D., the editor, explained the purposes well in his page: "In publishing the *Oakwood Hospital Clinical Journal* we hope to provide some satisfaction to the authors, and carry their messages to the greatest number of readers possible. We hope to stimulate the reader to quest more, or provoke him to respond in kind. We propose to devote subsequent issues to the research efforts of the intern-resident staff. Finally, we hope to acquaint the medical centers with Oakwood and thereby attract new friends."

Max L. Lichter, M.D., is the assistant editor.

The first issue includes seven scientific articles and also a message by S. E. Chapin, M.D., as Chief of Staff.

HONOR MICHIGAN EDUCATOR

Edwin G. Rice, the Michigan Department of Education's top health, fitness and recreation expert, has been elected president of the National Society of State Directors for Health, Physical Education and Recreation.

The organization will hold its annual summer workshop at the Kellogg Gull Lake Biological Station near Battle Creek from August 28 to September 2.

Describe Details of "MMS-MBC 65"

Michigan Blue Cross and Blue Shield has submitted a plan to the Michigan Department of Insurance for a special, low-cost health care plan to fill the gaps in the new Federal Medicare program.

Named "Blue Cross-Blue Shield 65," the coverage will be offered to all Michigan residents eligible for Medicare.

In a joint statement, Blue Cross President Wm. S. McNary and Blue Shield Executive Director John C. McCabe said that Medicare and Blue Cross-Blue Shield 65 will "provide the best combination of benefits and rates ever available to Michigan residents 65 and older, and will allow our 317,000 members in this age group to continue their valuable membership in Blue Cross and Blue Shield."

McNary and McCabe said the proposed monthly rate for the plan will be $5.36 a month for each non-group subscriber. Even lower rates, subject to merit adjustments, are available to those with existing group coverage. Groups will be offered several op-ional levels of coverage.

Regarding the offering of Blue Cross-Blue Shield 65, they said:

1. An explanation and selection form is being mailed this week to about 150,000 Michigan residents who currently are Blue Cross-Blue Shield individual subscribers not enrolled in groups.

2. Written and personal contacts are being made at the same time with about 15,000 Blue Cross-Blue Shield groups that may have retirees and elderly employes included in their groups.

3. On April 18, enrollment for the new Blue Cross-Blue Shield 65 will be opened for all those who will be 65 or older by July 1 and are not now Blue Cross-Blue Shield members.

"This program is specially tailored to fill the gaps which exist in the Medicare program," McNary and McCabe said. "In addition, Blue Cross-Blue Shield 65 will extend the Medicare coverage and give the elderly better-than-ever health care protection.

"Those eligible for Medicare are free to decline the voluntary Part B, but we are urging our subscribers to take full advantage of the Federal program. Any of our current members can keep their present Blue Cross and their present Blue Shield, if they are not signed up for Part B. However, it would be economically unwise for them to do so."

(Michigan Blue Cross and Blue Shield were named earlier this year by the Social Security Administration as the Federal Government's fiscal intermediaries in Michigan for Part A and Part B, respectively, of Medicare.)

Broadly speaking, Part A of Medicare applies to

For prompt, emphatic diuresis

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(BENZTHIAZIDE)

NEW FROM TUTAG for prompt, comfortable diuretic action with a balanced excretion of sodium chloride and a lower potassium loss under normal dosage and diet regimen

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.

S. J. TUTAG
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hospital care and Part B applies to physician services.

The new Blue Cross-Blue Shield 65 provides benefits for the coverage of deductible and coinsurance requirements of Medicare. In addition, the new coverage will extend the days of care and provide benefits anywhere in the world, which Medicare does not.

The basic benefits of Blue Cross-Blue Shield 65 include:

—Payment of the first $40 for inpatient hospital care and the first $50 per calendar year for inpatient physician services. Under Medicare, the patient would be required to pay these deductibles.

—The extension of Medicare benefits beyond the 90 days provided by Medicare. The non-group extension is to 120 days. Groups may have benefits extended to 365 days.

—Payment of the $10 a day for the 61st through the 90th day of hospitalization and the 20 per cent coinsurance for inhospital medical expenses. With Medicare only the patient would have to pay these coinsurance sums.

—Payment of the $5 a day for the 21st through the 100th day of care in a Medicare-qualified nursing home.

—Payment of the deductible requirements for outpatient services.

—Full benefits provided anywhere in the world. Medicare benefits are restricted to the United States and possessions.

McNary and McCabe said that Blue Cross and Blue Shield have received thousands of inquiries from subscribers who expressed concern about whether Medicare would mean an end to their memberships.

"All of our members," they said, "in fact, all Michigan residents eligible for Medicare, will be invited to enroll in Blue Cross-Blue Shield 65. The combination of Medicare and this new coverage will give them superb health care protection at a very modest cost."

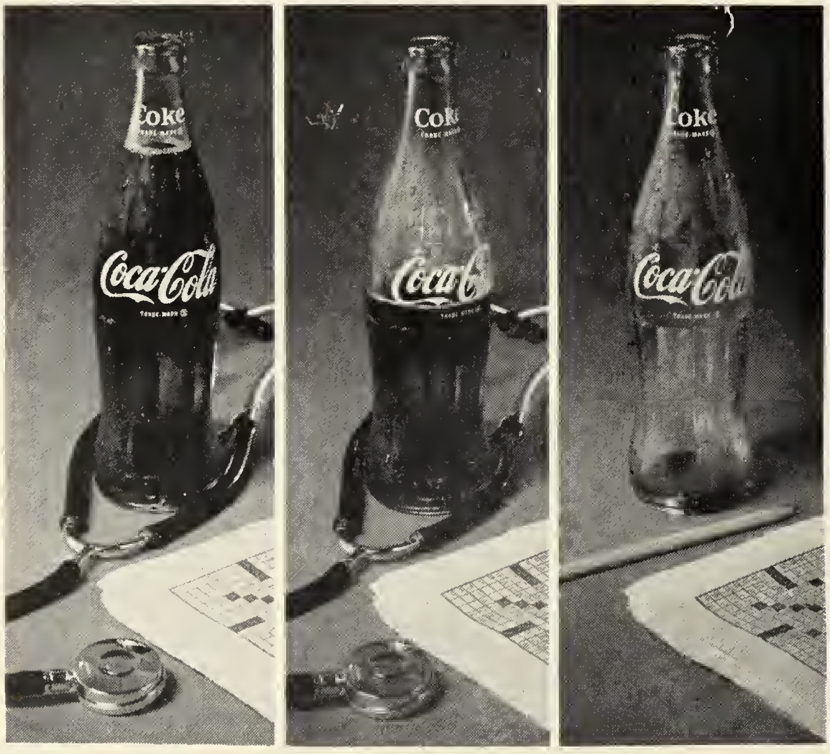
MMS to Add 200

Nearly 200 new employees will be hired by Michigan Blue Shield within the next few months to handle an estimated annual 7.8 million medical service reports from doctors.

The Department of Health, Education and Welfare selected the organization as an administrative agent for Medicare Part B on February 10, 1966.

Blue Shield expects the present volume of medical services to double with Medicare.

Currently 3.9 million services are provided annually by physicians to Michigan Blue Shield members.



11:47 pm **11:53 pm** **12:06 am**

The meaningful pause. The energy it gives. The bright little lift. Coca-Cola with its never too sweet taste, refreshes best. Helps people meet the stress of the busy hours. This is why we say things go better with Coke

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An antibiotic of choice is one that works

TAO works

Susceptibility Results
Staphylococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
6,725	1962	88.6%
5,440	1963	88.0%
10,384	1964	88.5%

β-Hemolytic Streptococci [2,3,1]

# OF CULTURES	YEAR	% EFFECTIVE
2,448	1962	89.5%
1,519	1963	95.2%
2,492	1964	96.7%

The Product

In a world study of antibiotics *in vitro*[1], TAO had an overall effectiveness of 87.3%, higher than chloramphenicol and erythromycin, and significantly higher than tetracycline and penicillin.

The Plus... Consistent Performance

Yet antibiotics must not only work. They must work consistently. Here are the results from the largest study of microbial susceptibility ever undertaken. In 29,048 cultures of overt staphylococcal and β-hemolytic streptococcal infections, note the consistency of results with TAO.

TAO®
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Division, Chas. Pfizer & Co., Inc., Science for the World's Well-Being®

TAO Rx information

Indications: The bacterial spectrum includes: streptococci, staphylococci, pneumococci and gonococci. Recommended for acute, severe infections where adequate sensitivity testing has demonstrated susceptibility to this antibiotic and resistance to less toxic agents. **Contraindications and Precautions:** TAO (triacetyloleandomycin) is not recommended for prophylaxis or in the treatment of infectious processes which may require more than ten days continuous therapy. In view of the possible hepatotoxicity of this drug when therapy beyond ten days proves necessary, other less toxic agents, of course, should be used. If clinical judgement dictates continuation of therapy for longer periods, serial monitoring of liver profile is recommended, and the drug should be discontinued at the first evidence of any form of liver abnormality. It is contraindicated in pre-existing liver disease or dysfunction, and in individuals who have shown hypersensitivity to the drug. Although reactions of an allergic nature are infrequent and seldom severe, those of the anaphylactoid type have occurred on rare occasions. **References:** 1. Isenberg, Henry D.: Health Laboratory Science **2**:163-173 (July) 1965. 2. Fowler, J. Ralph et al: Clinical Medicine **70**:547 (Mar.) 1963. 3. Isenberg, Henry D.: Health Laboratory Science **1**:185-256 (July-Aug.) 1964.

ANCILLARY MEETINGS

Auxiliary to AMA To Hear Appel, Others

The Woman's Auxiliary to the AMA will hold its 43rd annual convention June 26-30. More than 2,000 physicians' wives are expected to attend the meeting at Chicago's Drake Hotel.

A highlight of the four-day session will be a talk by Richard C. Cornuelle, author of "Reclaiming the American Dream." Mr. Cornuelle will speak at the June 27 Guest Day luncheon, to which representatives of national voluntary women's organizations will be invited.

Other events will include the June 26 reception honoring Mrs. Richard A. Sutter, St. Louis, Mo., Auxiliary president, and Mrs. Asher Yaguda, Newark, N. J., president-elect.

On Tuesday, June 28, national past presidents and AMA officers, trustees, and their wives will be guests of honor at a luncheon. James Z. Appel, M.D., AMA president, will be the speaker, and Auxiliary contributions to the AMA Education and Research Foundation will be presented. To date, the doctors' wives have raised more than $2 million for the foundation.

During convention business sessions, national chairmen will report on Auxiliary-sponsored community service programs in safety, rural health, disaster preparedness, mental health, health careers and international health activities.

The Auxiliary will also sponsor activities for physicians' children. Tours of Chicago landmarks, a baseball game and a barbecue are scheduled.

NEONATALITY SEMINAR SET

The 1966 Clinic Days of the Children's Hospital of Michigan and the Department of Pediatrics, Wayne State University School of Medicine, will be held May 19-20, at the Headquarters of the Wayne County Medical Society, Detroit.

The topic for the two-day symposium is "Recent Advances in Neonatality."

COMBINE HEALTH UNITS

Effective March 1, Alger-Schoolcraft and Luce-Mackinac Counties combined and will be known as the Alger-Schoolcraft and Luce-Mackinac Associated Health Departments. Gordon Eadie, M.D., will serve as health officer for both Alger-Schoolcraft and the newly-established Luce-Mackinac offices.

SAMA Convention Soon Out West

Leaders of the American medical community and delegates from more than 75 medical schools will gather in Los Angeles May 12-15 for the 16th Annual Meeting of the 60,000-member Student American Medical Association.

SAMA President James P. Moss, University of Louisville senior, will preside over the four-day session which is expected to attract 1,500 registrants to convention headquarters in the Statler-Hilton Hotel.

In addition to the scientific program the meeting will feature an 80-booth professional exhibit as well as numerous social events.

MUSCLE DISEASE SYMPOSIUM IN DETROIT, MAY 25

A Muscle Disease Symposium will be presented a the Wayne County Medical Society, 9 a.m. to 5 p.m. May 25.

The program will be a basic science and clinica consideration of multiple aspects of muscle disorder and disease, both primary and secondary. The biochemical and histochemical variations in red an white muscle fibers are considered from aspects o muscular dystrophy, nemaline myopathy, central cor disease, and myotubular myopathy. The remote effects of glandular, metabolic and viral infections ar considered on the neuromyogenic changes. Outstanding representatives of the Institute of Muscle Diseas will be the essayists. In the afternoon section, th various newer aspects of artificial muscle will be presented: myoelectric currents, exoskeletal attachment activated by exoskeletal motors in paralyzed an prosthetic limbs. This group will have physicists fron Philco Corporation, Cornell Aerospace Laboratories Temple University physiatrists, and neurophysiologists as discussants.

All inquiries should be made to Max K. Newman M.D., Department of Neurology, Wayne State University School of Medicine, Detroit.

HONOR MRS. COBB

The Kalamazoo County Medical Assistants Societ recently held a surprise birthday party on Mrs. Blanc Cobb in celebration of her 85th birthday. Mrs. Cob has been a member of the Kalamazoo group sinc 1951 and was made an Honorary Member in 195 She has served as Historian of the Society for th past ten years.

Night Leg Cramps...
Frequent Bedfellow in Diabetes, Arthritis, and Peripheral Vascular Disorders*

*"Nocturnal cramps occurring in the calf muscles and small muscles of the feet have been encountered in a significant number of diabetic patients."[1]

". . . nocturnal cramps may be the presenting symptoms of patients with arteriosclerosis obliterans, deep thrombophlebitis, varicose veins, osteoarthritis . . ."[2]

now...specific therapy for night leg cramps

QUINAMM ™

Consistently effective, QUINAMM provided complete relief in 94% of 200 patients studied, many of whom were severe cases refractory to other medication.[3] Your prescription for one tablet at bedtime often controls painful night cramps with the initial dose . . . helps restore restful sleep.

QUINAMM Prescribing Information: Composition: quinine sulfate 250 mg. and aminophylline 200 mg. per tablet. **Precautions:** aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue if ringing in the ears, deafness, skin rash or visual disturbances occur. Since Quinamm contains quinine sulfate, caution should be observed regarding administration during pregnancy. Dosage: 1 tablet three or four times daily. For nocturnal leg cramps, 1 tablet on retiring.

References: 1. Shuman, C.: Am. J. Med. Sci., 225:54, 1953. 2. Perchuck, E., et al.: Angiology, 12:102, 1961. 3. Rawls, W., et al.: Med. Times, 87:818, 1959.

WALKER Laboratories Division of Richardson-Merrell Inc. Mt. Vernon, New York 10551

MAP Congress Lists Dr. Howard, Freitag, Others

All members of MSMS, whether or not they belong to MAP, are invited to the Seventh Annual Congress of the Professions in Detroit, May 14-15, to hear exciting reports such as Ernest B. Howard, M.D., of the AMA, tell about his recent trip to Viet Nam.

Doctor Howard, Assistant Executive Vice President of the American Medical Association, will describe his recent trip to Viet Nam as a key member of a team to push forward the "war for men's minds" in the confusing war arena that is Viet Nam today.

Each Congress of the Professions has featured some particular facet of professional life. This year's theme is "Exploring the Worlds of the Professions."

Many provocative speakers have been obtained by the MAP Congress Planning Committee for the colorful meeting at the new Pontchartrain Hotel:

During the Saturday afternoon general assembly, Captain Robert F. Freitag of Washington, D. C., Director of Manned Space Flight Center Development, National Aeronautics and Space Administration, will talk about the knowledge explosion in the "scientific world of the professional."

At this same afternoon session, Dr. Paul W. McCracken, Professor of Business Conditions at the University of Michigan and former economic advisor to President Eisenhower, will talk about the "economic world of the professional."

Dr. Sigmund H. Schanderl, internationally known food scientist from Michigan State University, will present a fascinating symposium on Saturday evening just before a dinner dance honoring the "social world of the professional."

Following a gourmet breakfast on Sunday morning, Carl S. Winters, D.D., of Oak Park, Illinois Educational Consultant of the General Motors Corporation, will talk about the place of "religion in the professionals' world."

McCRACKEN

FREITAG

Other areas to be explored by top authorities will be the "organizational, legislative, and cultural worlds of the professions," represented respectively by Don H. Spangler, D.V.M., Atwater, Minnesota, President of the American Veterinary Medical Association; Mark Andrews, Washington, D.C., Congressman from North Dakota; and Michael P. Church, Ann Arbor, Director of Cultural Affairs, University of Michigan Extension Service.

The presidents of the state professional societies will act as Honorary Chairmen, including MSMS President Luther R. Leader, who is also a member of the MAP Board of Directors.

As usual the tab has been kept to a minimum with $5.00 as the registration fee; plus meal charges, of course.

Normally held earlier in the year, MAP placed its Congress this time to coincide with the beginning of "Michigan Week". Thus, "Professional Week" will be celebrated May 8-14 and "Michigan Week", May 15-21.

MEDISCENE

May 2-7—Western Michigan Health Fair, Muskegon

May 5—Conference on Medical Reporting, Kellogg Center, East Lansing

May 11-13—Michigan Public Health Association Annual Meeting, Pick-Fort Shelby Hotel, Detroit

May 13-14—Michigan Kidney Foundation Medical Symposium, David Whitney House, Detroit

May 14-15—Michigan Association of the Professions Congress, Pontchartrain, Detroit

May 15-21—Michigan Week

June 4-5—Seminar On Marriage Counseling, Boyne Hylands Inn, Harbor Springs

June 16, 17, 18—Upper Peninsula Medical Society Annual Meeting, Iron Mountain

June 22-25—Michigan Association for Retarded Children Conference, Northern Michigan University, Marquette

July 16-17—Upper Peninsula Seminar for Michigan State Medical Assistants, Sault Ste. Marie

Sept. 12-16—Michigan Nurses Association, Conference for Operating Room Nurses, Kellogg Center, East Lansing

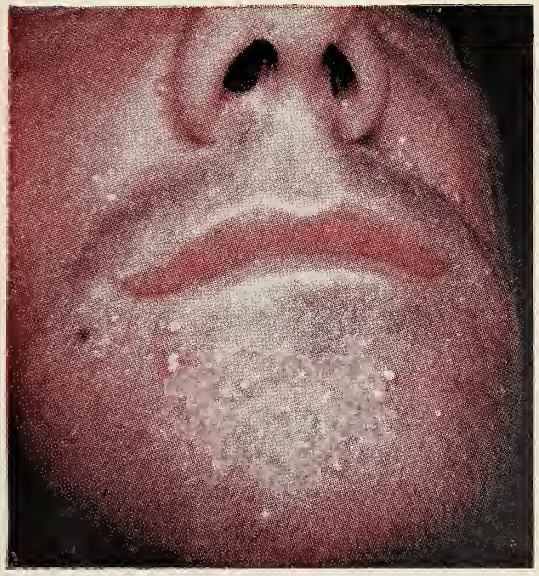
Sept. 25-27—Michigan State Medical Society House of Delegates, Pantlind Hotel, Grand Rapids

Sept. 26-27-28—Michigan State Medical Society Woman's Auxiliary, Pantlind Hotel, Grand Rapids

Sept. 28-30—Michigan State Medical Society Annual Scientific Session, Civic Center, Grand Rapids

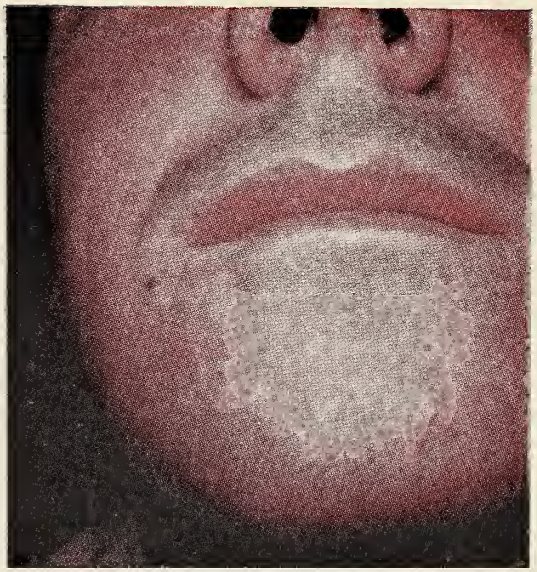
Sept. 28-29—Michigan State Medical Assistants Society Convention, Mr. President Motel, Grand Rapids

TOPICAL TREATMENT



PRIMARY PYODERMA

TYPICAL RESULTS



AFTER TREATMENT WITH
'NEOSPORIN' ANTIBIOTIC OINTMENT
AND SALINE COMPRESSES

with 'NEOSPORIN'® brand Polymyxin B-Neomycin-Bacitracin OINTMENT

Each gram contains:

'Aerosporin'® brand Polymyxin B Sulfate	5,000 Units
Zinc Bacitracin	400 Units
Neomycin Sulfate (equivalent to 3.5 mg. Neomycin Base)	5 mg.

Tubes of ½ oz. and 1 oz.

- clinically effective
- comprehensive bactericidal action against most Gram-negative and Gram-positive organisms, including Pseudomonas
- rarely sensitizes

For the eradication of infectious organisms in a wide range of dermatologic disorders: impetigo, ecthyma, pyodermas, sycosis vulgaris, paronychia, traumatic lesions, eczema, herpes and seborrheic dermatitis. Prophylactically, for protection against bacterial contamination in burns, skin grafts, incisions and other clean lesions, abrasions and minor cuts and wounds.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs.

Contraindication: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Complete literature available on request from Professional Services Dept. PML.

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Evaluate Hospital Needs in Grand Rapids

At a meeting before a United Community Services planning group in Grand Rapids, Professors William L. Dowling and Lawrence A. Hill, of the University of Michigan, presented the findings of a report on local health care needs. The University of Michigan team recommended that planning emphasis should be on home care, long-term care institutions and rehabilitation facilities, rather than on the construction of more $46-a-day hospital beds.

The University of Michigan report noted that Grand Rapids has about $35 million in major health facilities, including hospitals, and that it costs the community in taxes, insurance premiums and hospital bills about $20.3 million a year to operate them, or about $60 for every man, woman and child.

Yet the report indicates, about 20 per cent of the general, or "acute"hospital beds are occupied by patients who could be cared for as well in less expensive facilities, or even in their own homes if proper services were developed and their use encouraged. "People are accustomed to turn to the acute hospitals for all problems," Prof. Dowling said. "Many could get what they need in less expensive facilities, which are medically valid, and certainly economically valid."

The city will need 400 additional acute hospital beds by 1975, the report states, but Prof. Dowling said he had separate talks with administrators of local hospitals about expansion plans and he received the impression the city is about to get more beds than it needs, at least for some years. "I don't say these beds won't be used," Prof. Dowling said. "Hospital beds tend to fill up as soon as they are available."

Prof. Dowling said the role of the UCS planning unit would be to attract resources, encourage development of needed facilities, back up physicians in developing an efficient "pattern" of services for savings and efficiency, and be the local contact with county and state agencies, volunteer agencies and community organizations.

Speak Softly

If you expect to catch any fish on your vacation—speak softly. Fish have an exceptionally keen sense of hearing, particularly in the lower range, according to Otologist Dr. S. L. Shapiro. Many fishermen will swear that not only the splash of an oar but even a whisper is enough to send a previously unsuspecting fish off into the depths. Hearing studies of fish bear this out. Hearing range varies with different species: catfish hear the highest tones; minnows have a much lower limit but have an acuteness of hearing for a weak whistle sound exceeding that of a man submerged in a large tank. Man perceives as sound those vibrations ranging in frequency from 20 to 20,000 cycles per second (cps.). For most species of fish the keenest hearing lies in the 300-800 cps. range, with the high tone limit below 3,000 cps.

Eye, Ear, Nose & Throat Monthly

MSMS Maternal Welfare Conference in Focus

Among the participants at the 1966 Conference on Maternal Health were (left to right) John E. Wentworth, M.D., Flint, Genesee County Medical Society President; and four MSMS Maternal Health Committee members, Clarence E. Toshach, M.D., Saginaw; Richard T. Mellis, M.D., Kalamazoo; Vergil N. Slee, M.D., Ann Arbor, and Fred W. Bald, M.D., Flint.

The Bootie Hill exhibit (a perinatal mortality study) is explained by its creator, Lee B. Stevenson, M.D., Detroit, (left) to Wm. W. Jack, M.D., Grand Rapids, (center) MSMS Maternal Health Committee Chairman, and M. Edward Davis, M.D., Chicago, a conference speaker.

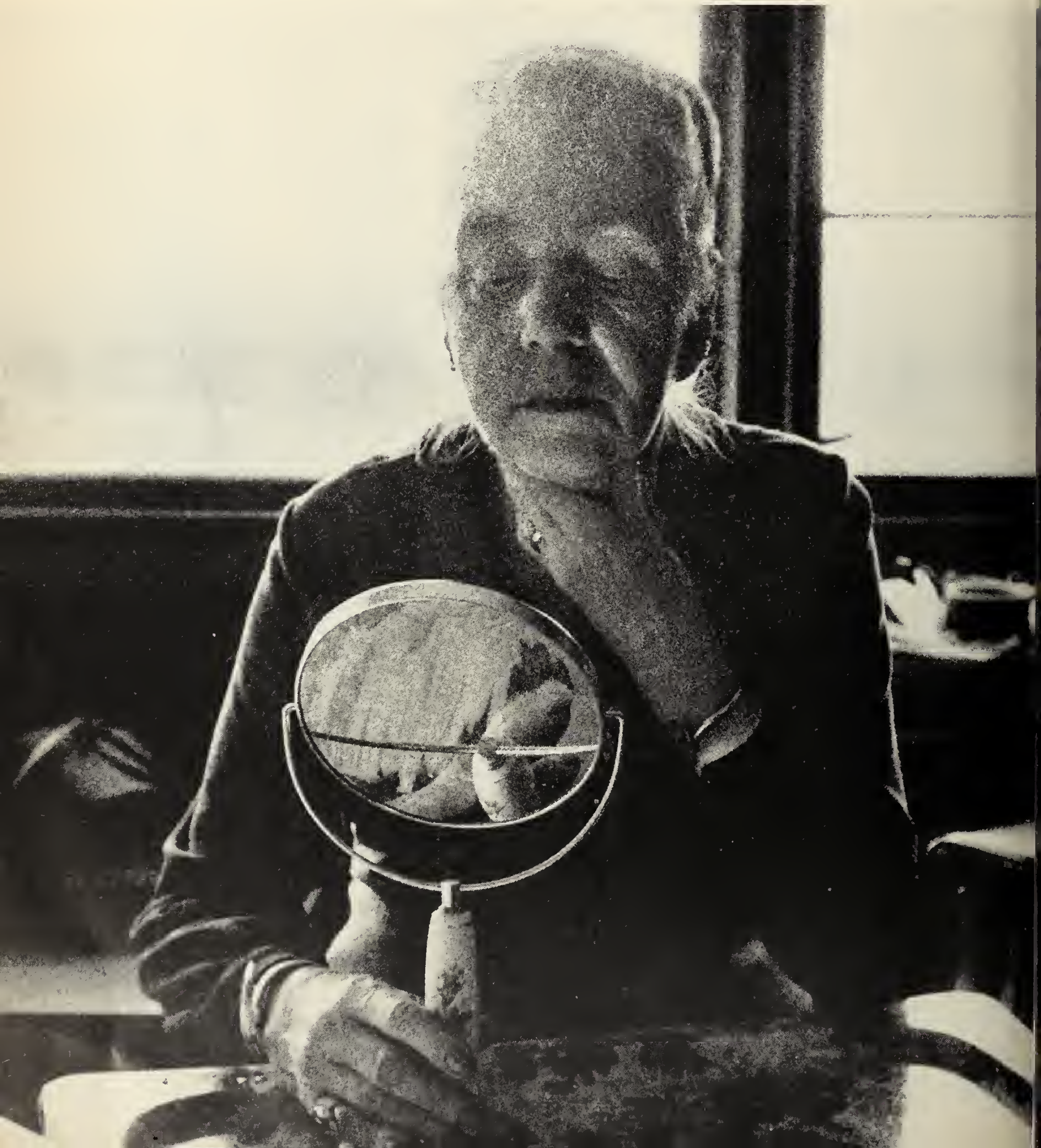
The Mediatric Age:

There is a growing senescent body of people who —either from lack of motivation, or as a result of surgery, trauma, or extended illness—are on their way to malignant inactivity...

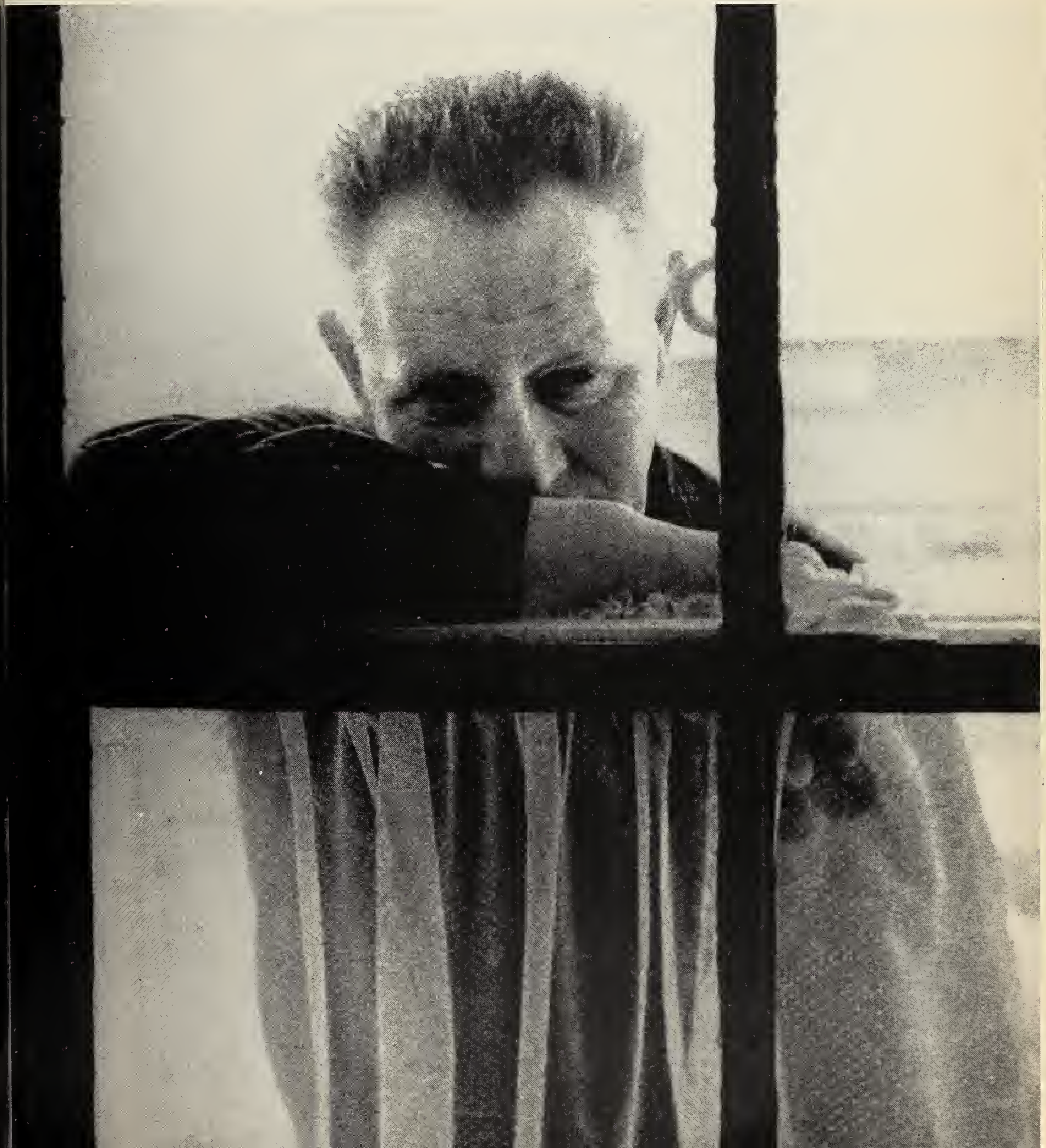
The Mediatric Age:

Some may be not quite sick, nor yet quite well. They may complain of too easy fatigue, of vague aches and pains.

Many need your assurance that they are not as old as they feel...

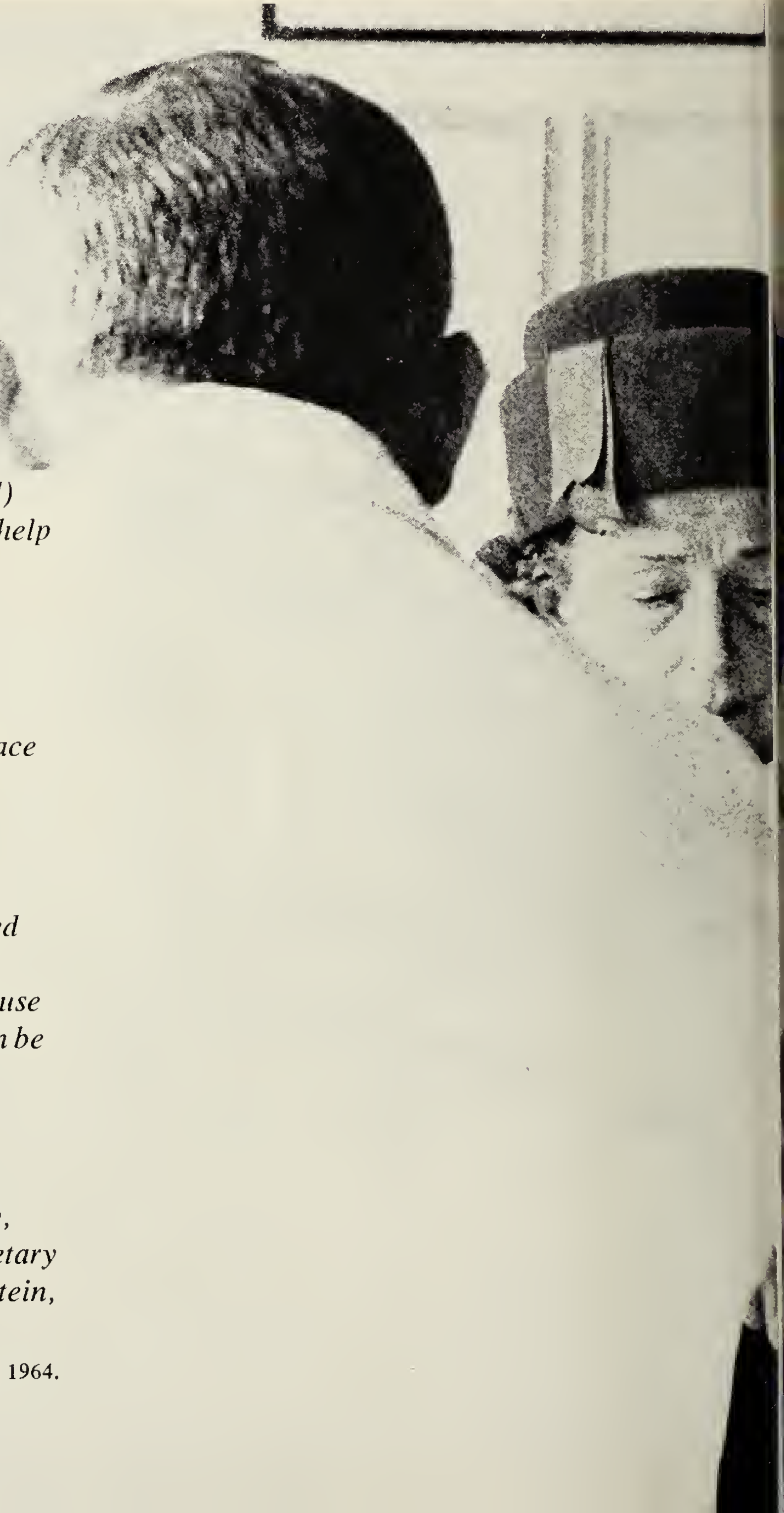


The Mediatric Age:
Frequently, they become "the waste-aways."
They have simply lost interest in
the maintenance of their own well-being—
often through the feeling
that they are no longer needed.



The Mediatric Age:

Unfortunately, there is no cure. But there are, largely through your own interest and direction, ways to help them back to a more active and useful life. There are medicines, too, designed to help. One such has proved useful in clinical practice:



"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging . . . This therapy resulted in improvement of 75 per cent of the patients . . ."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied . . . The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

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Designed for the "metabolically spent"

Nutritional reinforcement for those who can't – or won't – eat properly... balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes... mild antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation.* It contributes a *gentle "mood" uplift* through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

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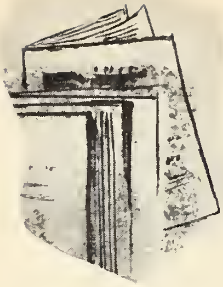
LEGAL OPINIONS



When You Suggest Patient Be Grounded:

(Editor's Note: The MSMS Council has authorized the publication of the following opinion by the MSMS Legal Counsel "as to whether or not immunity from liability does, or should, exist for the physician who voluntarily reports on physical condition of patients who should not drive or fly.")

Gentlemen:

As appears in the minutes of the meeting of your Committee on December 10, 1964, I have been requested to render an opinion "as to whether or not immunity from liability does, or should, exist for the physician who reports voluntarily physical conditions of patients who should not drive or fly."

The first part of the question is easily answered. Immunity from liability does not presently exist if a physician voluntarily reports the physical conditions of his patients to licensing authorities or others without the consent of the patient. Michigan is one of the states which strongly protects the physician-patient privilege. The Medical Practice Act (14.533 M.S.A.) provides that "the willfully betraying of a professional secret" constitutes "unprofessional and dishonest conduct" which is a ground for denial, suspension or revocation of a doctor's license.

Michigan also has a privileged or confidential communication statute (27.911 M.S.A.) which provides in part as follows: "no person duly authorized to practice medicine or surgery shall be allowed to disclose any information which he may have acquired in attending any patient in his professional character, and which information was necessary to enable him to prescribe for such a patient as a physician, or to do any act for him as a surgeon."

While this section is a part of the Judicature Act and pertains primarily to disclosures made in court without waiver of the privilege by the patient, I think it expresses the public policy of the state and that a doctor runs the risk of liability if he discloses information without his patient's consent.

The second part of your question which asks whether immunity from liability should exist is not primarily a legal question but one of policy upon which there is perhaps a wide variance of opinion.

I see no reason why the legislature could not grant such immunity were it so inclined but, personally, I continue to adhere to the view expressed to the Chairman of your Committee in 1962 that granting immunity and requiring mandatory reporting by doctors to governmental agencies is not desirable. I believe that the maintenance of the physician-patient privilege is an essential to good medical practice and that its gradual erosion through more and more exceptions is not in the interest of good medical practice.

Sincerely yours,
LESTER P. DODD
Legal Counsel, MSMS

NEWS HIGHLIGHTS OF COUNTY SOCIETIES

Live surgery by veterinarians will be one of the highlights at the West Michigan Science Fair, to be presented at Muskegon by the **Muskegon County Medical Society,** May 2-7. The MSMS Healthmobile will be one of the other features of the event at the Walker Arena.

* * *

The **Cass County Medical Society** has contributed funds to the Cass County Library to purchase books in memory of D. H. Swengel, M.D., former Cassopolis physician.

* * *

The annual "Doctor-Clergy Day" recently was held in Kalamazoo under the joint sponsorship of the Bronson Methodist Hospital, **Kalamazoo Academy of Medicine** and the Kalamazoo Ministerial Alliance. The guest speaker was Richard L. Baumgartner, M.D., Ohio psychiatrist.

* * *

The **Monroe County Medical Society** recently hosted the county lawyers, dentists, and coroners. The speaker was Edward S. Zawadzki, M.D., chief medical examiner of Wayne County. He discussed the medical-legal investigation of death as handled in Wayne County.

* * *

The Allegan County Medical Society was one of four agencies and associations which conducted a voluntary TB testing program throughout the county. The Mantoux skin test was done only when parents signed consent cards.

* * *

The recent Tecumseh Junior High School Career Day included the AMA film, "Helping Hands for Julie," a display and two members of the **Lenawee County Medical Society** as consultants. The physicians reported great interest, too, in the career pamphlets.

This “case history” runs to some 10,000 pages

This is a typical "case history" of one new drug—or, rather, a proposed new drug—assembled for submission to the U.S. Federal Food and Drug Administration. These volumes are the result of several years' work by thousands of professional and skilled personnel in just one pharmaceutical company's research laboratories, and by hundreds of physicians in medical schools, hospitals, and private practice. They cover every aspect of experience with this proposed new agent from chemical laboratory to clinic, from mouse to man. Each volume could conceivably represent hundreds of thousands of dollars of financial investment, countless hours of human effort. This veritable mountain of data stands behind every new agent offered to you by pharmaceutical manufacturers—a reassuring testimonial to the efficacy, safety and purity of the drugs you will prescribe today to lower the cost of disease to your patients.

Pharmaceutical Manufacturers Association
Pharmaceutical Advertising Council
1155 Fifteenth St., N. W., Washington, D.C. 20005

This message is brought to you as a courtesy of this publication on behalf of the producers of prescription drugs.

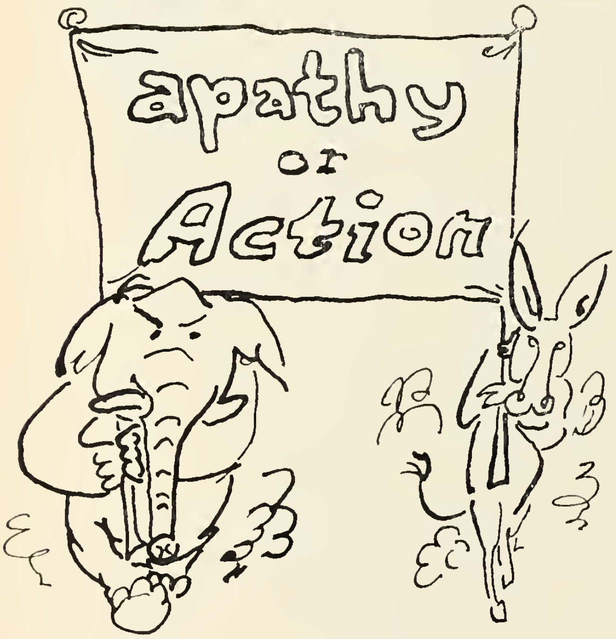
More Clarification On FDA Regulations

The February issue of *Medigram* included a letter from the Pharmaceutical Manufacturers Association explaining Food and Drug Administration regulations regarding physician record-keeping requirements.

One of the regulations declared: ". . . (the) maintaining of small supplies of these drugs for dispensing or administering in the course of professional practice in emergency or special situations will not be considered as regularly engaged in dispensing for a fee."

The final FDA regulations now contain examples of fact situations in which the above provision would apply: Emergency or special situation dispensings include dispensings "as a stopgap measure to tide patients over until a regular supply of drugs can be obtained by prescription from a pharmacy, or dispensings as trial doses to patients . . ." These are, of course, instances in which a physician will not be considered to be regularly dispensing. It should be noted in addition that under the wording of the statute even when a physician does regularly dispense, he need not maintain records unless he, in some way, charges for the drug.

This information is provided by C. Joseph Stetler, President, Pharmaceutical Manufacturers Association.



Political apathy will be attacked on June 5 when MDPAC holds a workshop at the Sheraton-Cadillac Hotel, Detroit, for county society representatives and interested physicians and wives. See page 379 for details.

1966 ELECTION CALENDAR

Michigan voters on November 8 will select a new Governor, Lieutenant Governor, all state Representatives and Senators, two members of the State Board of Education, two members of the MSU Board of Trustees, two members of the U-M Board of Regents, two members of WSU Board of Governors, two members of the Michigan Supreme Court, Secretary of State, Attorney General, one U.S. Senator, and 19 U.S. Representatives.

The election calendar for May, June and July follows:

May 24—Last day for candidates for precinct delegates to the county convention of each political party to file nominating petitions.

June 3—Last date for the State Central Committee of each political party to issue the call for the Fall State Convention of such political party.

June 11—The last date for candidates to file fees to qualify for filing nominating petitions.

June 14—Last date for partisan and non-partisan candidates to file nominating petitions.

June 18—Last date for the State Central Committee of each political party to issue the call for county conventions.

July 5—Last date to register for the primary election. Places for registration are to be open between the hours of 8 a.m. to 8 p.m.

July 11—Last date for filing of petitions by qualified and registered electors proposing an amendment to the State Constitution. Such petitions are to be filed with the Secretary of State.

July 30—Deadline for absentee ballot applications for the primary election. Such applications must be made by 2 p.m.

PREDICTS BREAKUPS OF POLITICAL CAMPS

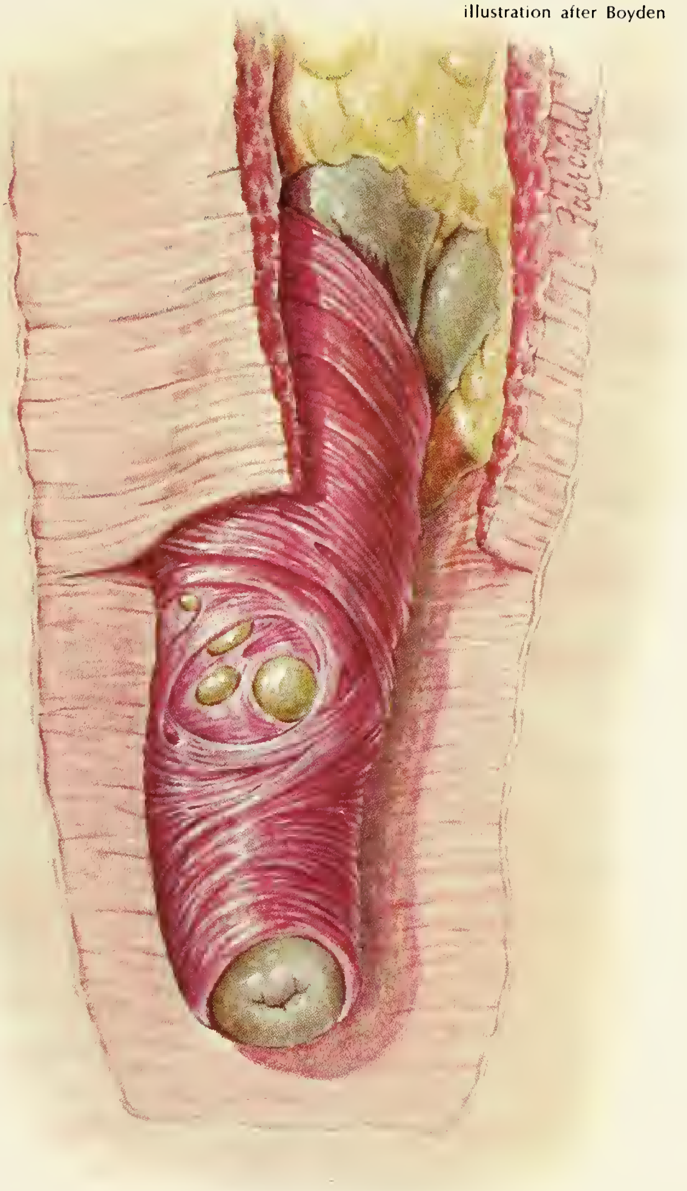
Megalopolis may flex political muscles, points out Robert P. Gerholz, of Flint, president of the U.S. Chamber of Commerce.

In a recent speech in Des Moines, Mr. Gerholz indicated that the creation of "megalopolis strips" will unleash new political rivalries and new forms of alliance.

When that happens, Mr. Gerholz asserted, "the people of the United States may see the tunes being called from places other than Washington."

And this, he added with some relish, may produce some "likely advantages" to reverse the trend toward "a lapse into a one City-State called Washington."

illustration after Boyden



HOW IMPORTANT IS THIS
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PERHAPS VERY IMPORTANT

The sphincter of Oddi is made up primarily of smooth muscle fibers. It permits the gall bladder to fill, regulates the flow of bile and pancreatic enzymes and in dysfunction is a primary cause of Biliary Dyskinesia. The sphincter of Oddi is but one of five major foci of smooth muscle spasm where SPACOLIN® (Alverine citrate) acts directly with rapid onset and long duration. No neurotropic side effects because Spacolin is a musculotropic counter-spasmodic unrelated to atropine or atropine-like drugs. Spacolin is not contraindicated in prostatic hypertrophy.

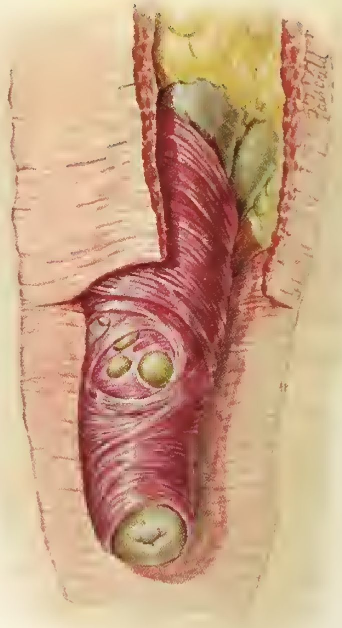
SPACOLIN® (Alverine citrate)

Each tablet contains: Alverine citrate . . . . 120 mg.

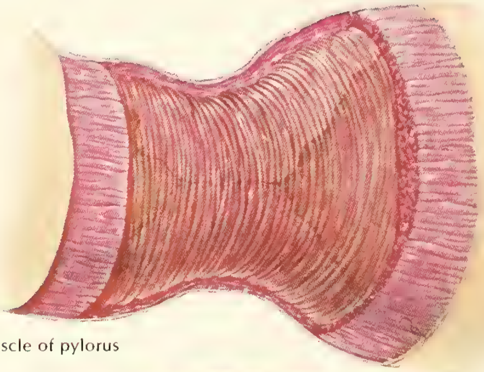
INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

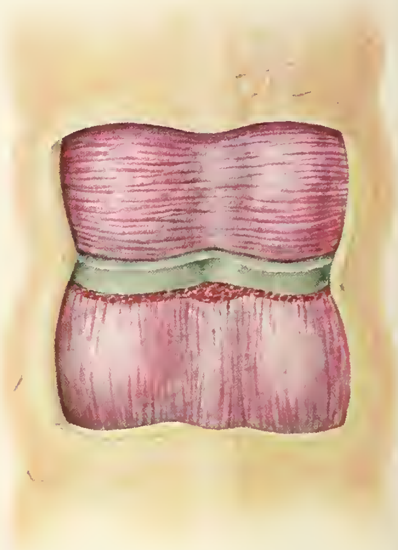
PHILIPS ROXANE LABORATORIES Division of Philips Roxane, Inc.,
Columbus, Ohio



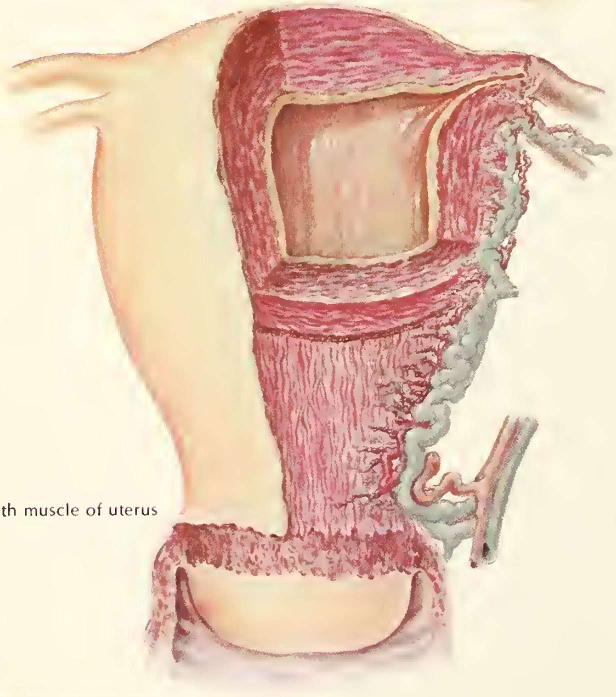
smooth muscle sphincter of Oddi



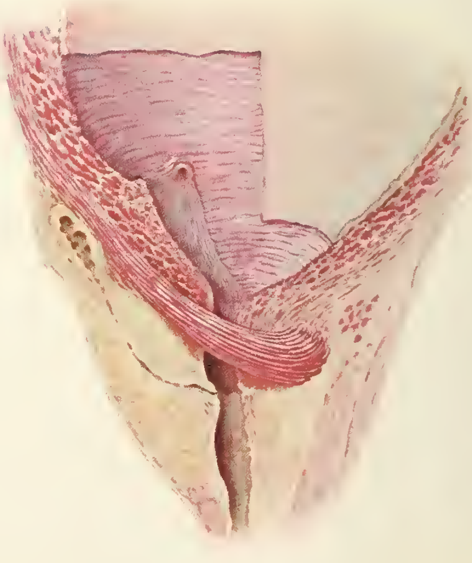
smooth muscle of pylorus



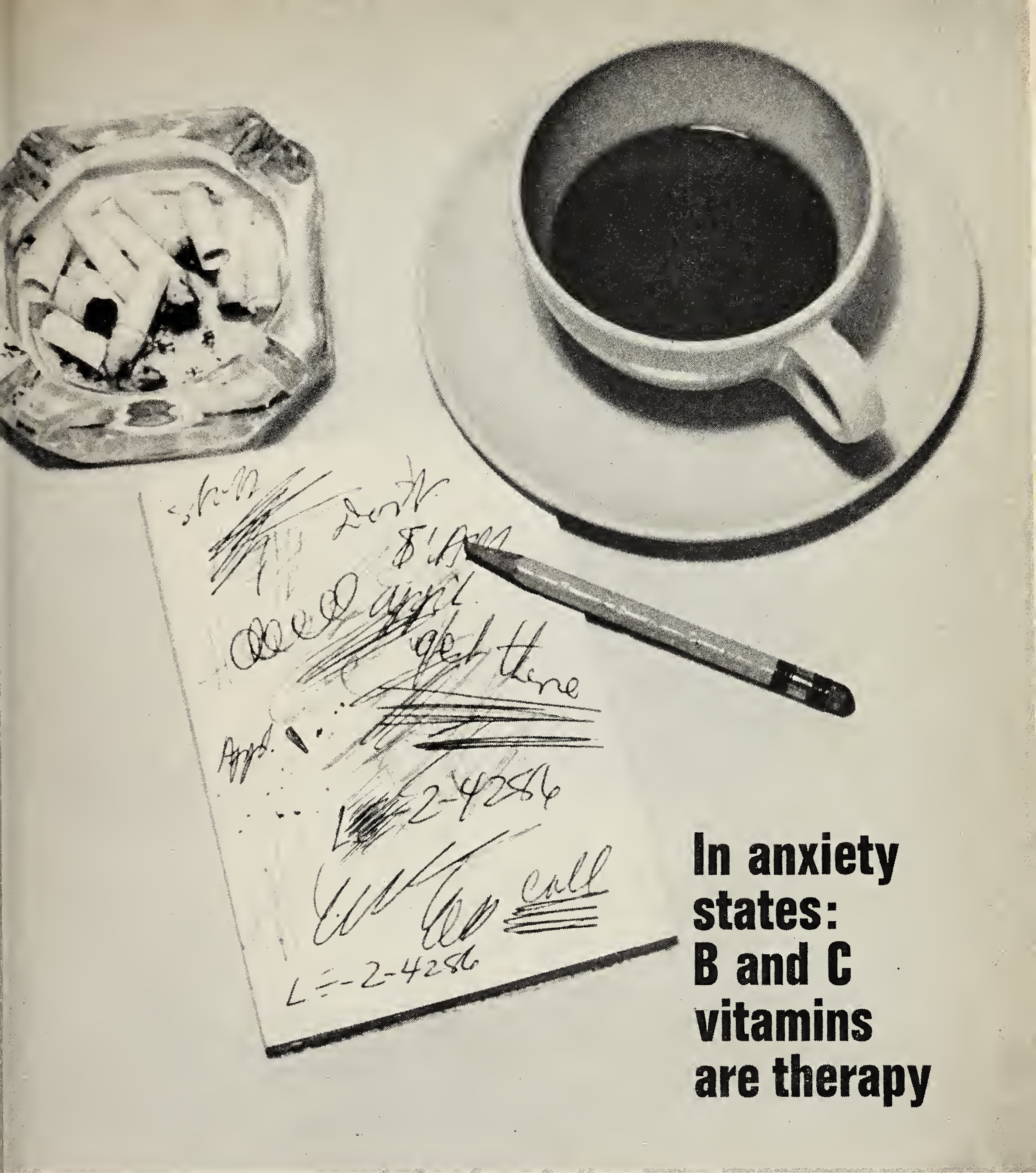
smooth muscle of colon



smooth muscle of uterus



smooth muscle of urinary bladder



ess formula vitamins are an important supportive measure in main-
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RESSCAPS, B and C vitamins are present in therapeutic amounts to meet
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Vitamin B_1 (as Thiamine Mononitrate)	10 mg.
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Niacinamide	100 mg.
Vitamin C (Ascorbic Acid)	300 mg.
Vitamin B_6 (Pyridoxine HCl)	2 mg.
Vitamin B_{12} Crystalline	4 mcgm.
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Recommended intake: Adults, 1 capsule daily, for the treatment of vitamin deficiencies. Supplied in decorative "reminder" jars of 30 and 100; bottles of 500.

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How to Work With Health Groups

Six suggestions are offered for county medical societies to promote understanding of allied health agencies.

They are:

1. Become informed on the stated purpose, organizational pattern, and program of each health agency represented within the jurisdiction of the medical society.

2. Acquaint the medical society members with all information obtained so they may inform their friends and patients correctly.

3. Offer liaison through appropriate medical society committees in order to strengthen the scientific programs of health agencies and insure their compliance with accepted medical opinion.

4. Offer the consultation of medical society members of appropriate specialty to the smaller and less well-organized health agencies to insure a medically correct and an ethically acceptable program.

5. Encourage health agencies to select physicians for membership on their governing bodies from among medical society members in good standing, or from a panel of members submitted by the medical society as suggested nominees.

6. Help physicians serving health agencies to recognize their variation in role with variation in circumstance, particularly that only a physician appointed by a medical society can be the official representative of that society.

These suggestions are part of the Suggested Guides to Relationships between Medical Societies and Voluntary Health Agencies, adopted by the AMA House of Delegates.

The AMA statement also, in part, states that “a physician selected by a voluntary agency to serve c
its board serves as an individual. He may know med
cal society policy but has no authority to speak for tl
medical society unless granted that authority l
action of the medical society. Physician membersh
on a board of directors is desirable and is to be e
couraged even though such members represent tl
medical society only in an informal way and not
its official spokesman.”

OFFER GUIDELINES RE HEALTH GROUPS

Copies of the AMA “Suggested Guides to Relationships between Medical Societies and Voluntary Health Agencies” were distributed at the 1966 MSMS Officers Conference.

Any interested doctor of medicine who writes to Council Chairman Hiscock at MSMS headquarters may request a copy.

Following is a three-point summary made in tl
AMA statement:

1. The voluntary health agency is now a reco
nized community function, and most agencies me
medical society support of their objectives thoug
the medical society, in some instances, might pre
for changes in policy or procedures.

2. Medical societies and voluntary health agenci
have mutual obligations. Medical societies should pa
ticipate and when desired give agencies advice an
counsel on the medical and civic aspects of con
munity needs. Voluntary health agencies shoul
establish liaison with the medical society and fran
their programs to conform to sound medical practic
3. Physicians should support voluntary healt
agencies within their sphere of interest, and recogni
whether their role is an official representative of tl
medical society, interested physician or private citize

HOW DOES AMA HELP DOCTORS IN PRACTICE

Here’s how:

The AMA provides early unbiased information o
all types of new drugs . . . sponsors two huge pos
graduate conventions annually and many speci
symposia and conferences . . . publishes 11 scientifi
journals and a medical newspaper . . . maintains
physicians’ question-and-answer service . . . works fo
higher standards of internship and residency trainin
. . . exerts leadership to solve medical problems a
they arise and serves as a vast clearing house on sci
entific medicine . . . studies the ever-increasing prob
lems related to the nonscientific side of medicin
probing questions and developing action program
. . . maintains extensive libraries and library lendin
services . . . provides office planning guides and prac
tical aids . . . studies and reports on patterns of prac
tice . . . publishes pamphlets for distribution to pa
tients . . . serves as clearing house for informatio
on state legislation of medical interest, and analyze
medical legislation introduced in Congress . . . keep
up-to-date records on all physicians . . . offers score
of other services designed to keep the physician abreas
of the times and to help him practice the best medi
cine.

Says Good PR Up to Doctor

By James P. Muldoon, M.D.
Grand Rapids

(The following are excerpts from an article by Doctor Muldoon in the monthly publication of the Kent County Medical Society.)

The crucible of public relations for American medcine has been in the past and is at the present time ound to reside within the confines of each doctor's ffice. The most effective public relations man workng for organized medicine today is the individual racticing physician.

From very ancient times, medicine in some form as been an integral component of every society. Our ociety is no exception. Medicine is so much a cenral part of our society that it affects almost every spect of our culture.

Perhaps it is time that certain basic questions were osed and answered.

1. What are the true dimensions of medical science n medical care?

2. How far does medical care extend into the ructure of our society?

3. To what extent is medicine concerned with iseases and disorders in and of society—with probems such as delinquency, crime, alcoholism, fitness f an individual to drive a car, or with the fitness and afety of the environment, be it the atmosphere, an ndustrial plant or an automobile?

4. What are the true implications of medicine's ommitments to "the advancement of the science and rt of medicine and the betterment of public health"?

5. To what extent should medicine be concerned ith the biological survival and evolution of the uman species and its culture?

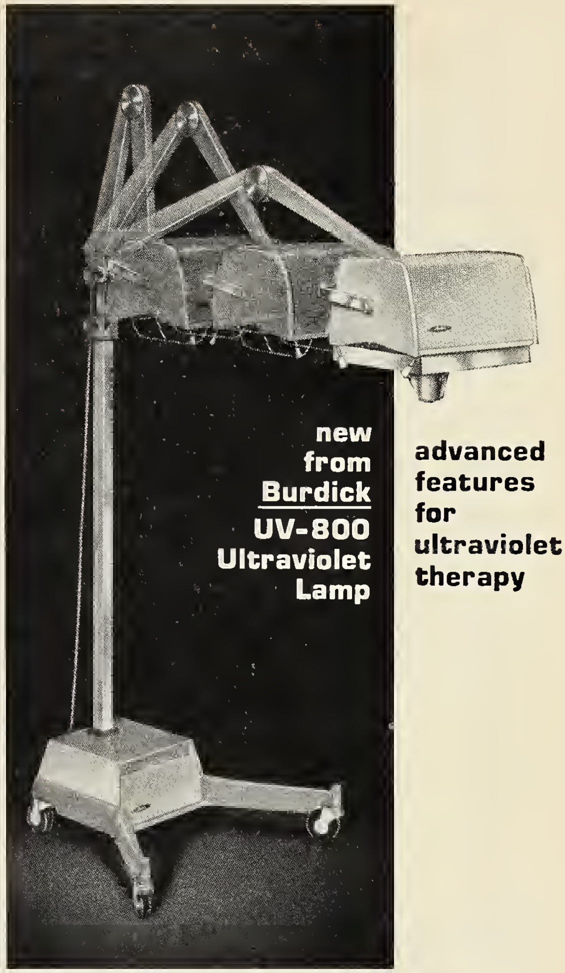
These are fundamental questions. Basically they sk what is the definition of modern medicine and ho is to be physician for modern medicine to modrn society. At the moment no one plays this essenal role and in a very real sense society is seeking its hysician.

Medicine needs good public relations and only you, octor, can effect it.

HELPS UNDERGRADS

A memorial fund of $304,051 has been established t The University of Michigan to provide scholarships r undergraduate medical students.

The fund, to be known as "The Frank B. and Lucy I. Ainger Fund," was made possible by the will of e late Lucy M. (Mrs. Frank B.) Ainger of Detroit.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Burdick's unique **Equipoise Arm** gives you "full-reach" over the treatment table, and easy positioning for any treatment situation. Reflector unit floats into position with finger-tip ease — and holds. Reflector unit rotates 360° on its own axis, allowing the operator to select the correct angle and position for any treatment. New **"Localizer"** with 2-inch cone (supplied as standard equipment) permits uniform focusing of radiation to small treatment areas. The **Localizer** may be quickly attached to the reflector hood, and easily removed.

Telescoping vertical column permits storage of the UV-800 in a compact space. Shutters mounted inside the reflector effectively shield stray radiation when the lamp is not in use. Wide-stance base and large, easy-rolling casters give the UV-800 easy mobility and good stability during treatments. Efficient, high-intensity radiation — full mercury arc spectrum — short treatment time — long tube life. Now is the time to modernize your ultraviolet equipment. Consider all the features of the stylish new UV-800, then see your Burdick dealer or write The Burdick Corporation, Milton, Wisconsin 53563, about trading-up!

Medical Arts Supply Co.
311 State Street
Grand Rapids, Michigan

On Taking Advice . . .

(The following newspaper column appeared in "The Northville Record" recently.)

By Bill Sliger

I can remember the day (before Medicare) when writing for the local press was considered most undignified by most self-respecting medical societies.

Doctors (M.D.'s, that is) would hardly give you statistics on an epidemic wiping out the community for fear someone might interpret it as "advertising"—and anyone knew that a doctor who would advertise for business would probably operate with unsterile instruments.

Anyway, the medical societies have become more human of late. They're sending out helpful health hints, suggestions for treating sunburn, heatstroke, etc. Our mail is full of such releases—and, frankly, their little campaign to prove that they are, after all, mere mortals has worked on me.

I always read what they have to say. It's like getting a free tip from a golf pro. The other day, for example, I read a column—I can't remember where—that advocated taking naps.

The particular doctor-columnist was rather clever. He said it's a good thing for your health to "be caught napping."

I've always been a great believer in naps. But this doctor really clinched the theory for me. He said that naps are better than exercise in promoting good circulation and preventing coronary attacks.

I've been hearing a little static around the house lately about "getting more exercise" and "losing a little weight."

But since reading the advice of the doctor-columnist, I don't think I'll rush into any such crash program.

I'll take my exercise napping.

Hails Healthmobile

The Healthmobile is an excellent method of not only presenting a historical background for Michigan medicine, but promotes health education in the community in a dignified and clearly understood manner. There are items of interest to most of the members of the family.

It was well received in this county and I believe assisted materially in public relations, for both the county and state medical societies.

Robert E. Rowe, M.D., *Director*
St. Clair County Health Department
Port Huron

BRIGHTON HOSPITAL

A non-profit foundation

FOR ALCOHOLISM

Member, Michigan Hospital Association

A facility designed to rehabilitate and aid the compulsive drinker in arresting his addiction.

Brighton Hospital meets the standards established by the Michigan State Board of Alcoholism and is recommended by that Board.

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One block south of I-96 at Kensington Rd. Exit
Four miles east of U. S. 23
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ACademy 7-1211

brings
peace to the
hyperactive
colon

CANTIL®
(mepenzolate bromide)

helps restore normal motility and tone

"In 40 of 44 cases of irritable or spastic colon, Cantil [mepenzolate bromide] or Cantil with Phenobarbital reduced or abolished abdominal pain, diarrhea and distention and promoted restoration of normal bowel function . . . Cantil [mepenzolate bromide] proved to be singularly free of anticholinergic side-effects . . . Urinary retention, noted in two cases was eliminated in one by reducing dosage."[1]

IN BRIEF: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required.

Dryness of the mouth or blurring of vision may occur but it is usually mild and transitory. Urinary retention is rare. Caution should be observed in prostatic hypertrophy—withhold in glaucoma. Cantil with Phenobarbital is contraindicated in patients sensitive to phenobarbital.

Supplied: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

[1] Riese, J. A.: Amer. J. Gastroent. 28:541 (Nov.) 1957

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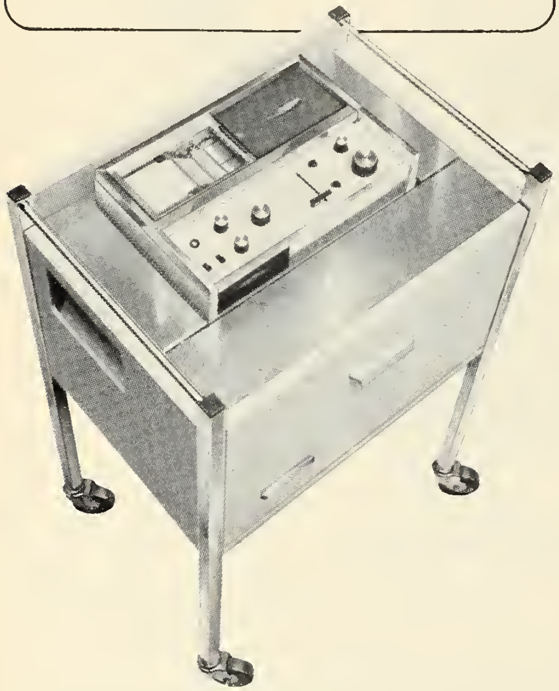
The dramatically new
Burdick EK 4
Electrocardiograph



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Take a look at the Burdick EK 4! Many important improvements have been made in electrocardiographs in recent years — this is why we invite your closer inspection of the EK 4. Reliability, diagnostic accuracy, and freshness of design are apparent in every detail. Precise recordings of high fidelity ● Designed for use with auxiliary equipment, phone transmission, permanent recording of monitoring phenomena ● Fast switching from lead to lead ● 25-50 mm. speeds ● ½ x 1 x 2 standardization on all leads ● High frequency response permits use with PC-100 Heart Sound Preamp ● Stable ● Lightweight. If your present ECG can't offer you these up-to-date features, take a closer look at the EK 4. The EK 4 is a sound investment for your practice or department, and it's backed by Burdick dealer service. Write us. The Burdick Corporation, Milton, Wisconsin 53563.

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4444 Woodward Avenue, Detroit, Michigan 48201
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In Memoriam

Gayle E. Canter, M.D., Royal Oak

Gayle E. Canter, M.D., Royal Oak surgeon, die March 12 in Highland Park General Hospital.

Doctor Canter was a graduate of the University Cincinnati School of Medicine and served as a su geon on the staff at Highland Park General Hospit for 35 years.

Bruce R. Elliott, M.D., Ovid

Bruce R. Elliott, M.D., 67, past president of t Clinton County Medical Society, died March 13 Clinton Memorial Hospital.

A native of Pontiac, Doctor Elliott was graduate from the University of Michigan Medical School i 1930. Doctor Elliott practiced in Ovid for 32 year coming there from Laingsburg where he practice from 1931 to 1934. Doctor Elliott was affiliated wit Clinton Memorial Hospital, St. Johns, and Memori Hospital, Owosso.

Lynn A. Ferguson, M.D., Grand Rapid

Lynn A. Ferguson, M.D., 74, Grand Rapids su geon, died March 21 in Arizona while en route hom from a California vacation.

Doctor Ferguson graduated from the University of Michigan Medical School in 1917. In 1928 he wa founder of Ferguson-Droste-Ferguson Hospital i Grand Rapids and served as chief of its medical sta and president of its Board of Trustees. His othe hospital affiliations included St. Mary's, Blodgett an Butterworth Hospitals of Grand Rapids, and Gran Haven Municipal Hospital, Grand Haven.

Doctor Ferguson was Past President and a Lif Fellow of the American College of Gastroenterolog and was its Secretary General at the time of his deat He was a Fellow of the International College Surgeons and an Honorary Fellow of the Brazilia Proctologic Society.

Active in U of M alumni, Doctor Ferguson wa secretary of his graduation class since 1917, past di rector of the Michigan Alumni Association and pas president of the class officer's council. He served a Michigan State Secretary of Alpha Kappa Kapp medical fraternity, for many years.

Doctor Ferguson authored many articles on proctol ogy and designed several instruments for the specialt

alph Lee Fisher, M.D., Detroit

Ralph Lee Fisher, M.D., 68, long-time Detroit hysician, died March 11 of a heart attack in his ffice at the Riverside Clinic of which he was a unding partner.

A graduate of Johns Hopkins Medical School in 922, Doctor Fisher's hospital affiliations included on Secours, Deaconess, St. John and Cottage Hositals, all of Detroit. Doctor Fisher was a fellow of e American College of Physicians and a diplomate the American Board of Internal Medicine. He as a member of Alpha Kappa Kappa Medical Frarnity.

During World War I Doctor Fisher served in the nited State Infantry.

uth Berkman Goldman, M.D., outhfield

Ruth Berkman Goldman, M.D., Detroit area physian and surgeon for 22 years, died March 22 at her sidence in Southfield. She was 48.

A native of Waco, Texas, Doctor Goldman was aduated from Baylor University Medical School in 941. Doctor Goldman served her internship at oman's Hospital, Baltimore, Maryland, and took stgraduate work at Jean's Hospital, Philadelphia, ennsylvania. At the time of her death Doctor Goldan maintained offices in Farmington and was on e staff of Brent Hospital.

Doctor Goldman was an Associate Member of the ichigan State Medical Society.

rthur S. Kimball, Jr., M.D., attle Creek

Arthur S. Kimball, Jr., M.D., medical director of e Arthur S. Kimball Sanatorium, Battle Creek, died arch 13 at Community Hospital there. He was 53.

A third generation Battle Creek physician, Doctor imball was born in that city. He obtained his medil degree in 1939 from McGill University, Montreal, uebec. Doctor Kimball joined the staff of the Oaknd County Tuberculosis Sanatorium in 1939, and o years later was named medical director. In 1947 returned to Battle Creek to become medical dictor of the sanatorium, which had been opened in 24 and in 1943 had been named for his father who is instrumental in its establishment.

His professional affiliations included membership the American College of Chest Physicians, the nerican Thoracic Society and the Michigan TB d Respiratory Disease Association.

William M. Murphy, M.D., Mt. Clemens

William M. Murphy, M.D., Mt. Clemens, died February 24 at his residence. He was 67.

A native of Park Hill, Ontario, Doctor Murphy received his medical degree from the University of Toronto Medical School in 1924. He entered practice in Detroit in 1930 and was on the Board of Directors at Detroit Memorial Hospital.

During World War I, Doctor Murphy served with the Royal Flying Corps.

Ellery A. Oakes, M.D., Manistee

Ellery A. Oakes, M.D., 71, Vice Speaker of the MSMS House of Delegates in 1944-45, died February 24 at Veterans Hospital, Ann Arbor.

Doctor Oakes was a Past President of the Manistee County Medical Society and served as a delegate to the Michigan State Medical Society, and was a former member of the Board of the Michigan Medical Service.

A graduate of Wayne State University School of Medicine in 1925, Doctor Oakes began practice in Manistee in 1926. He was affiliated with Mercy Community Hospital, Manistee, and was a former chief

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of staff of the Manistee County Medical Care Facility from which he retired in 1963 when he retired from active medical practice. Doctor Oakes was a member of Phi Rho Sigma medical fraternity.

During World War I Doctor Oakes was a sergeant first class in the U.S. Army.

Doctor Oakes was a retired member of the Michigan State Medical Society.

Donald A. Pollock, M.D., Port Huron

Donald A. Pollock, M.D., Port Huron, died in Port Huron Hospital on February 16. He was 62.

The son of the late Alexander Pollock, M.D., Doctor Pollock practiced medicine in Yale from 1932 to 1948. At that time he moved to Port Huron where he had since made his home. A graduate of the University of Michigan Medical School, Doctor Pollock was a professor there. Doctor Pollock was on the staff of the University of Michigan Hospital.

Doctor Pollock was an Associate Fellow of the American College of Surgeons and an Associate Member of the Michigan State Medical Society.

Frank P. Raiford, Sr., M.D., Detroit

Frank P. Raiford, Sr., M.D., died March 12 his home in Detroit at age 75.

A Detroit resident for 46 years, Doctor Raifo was born in Columbus, Ga., and received his medic degree from the University of Michigan Medic School in 1917.

Doctor Raiford was a founder of Boulevard Ge eral Hospital, formerly Trinity Hospital, Detroit, ar the Mack Avenue Sanitorium of that city. He w a member of Alpha Phi Alpha fraternity and tl National Medical Association.

Among the survivors is a son, Frank P. Raifor III, M.D.

Doctor Raiford was a Life Member of the Mich gan State Medical Society.

Timely Tip

Buckle down and stay safe. Your chances of being killed in an accident increases five times if you are thrown from the vehicle. Studies show that use of seat belts can eliminate at least one-third of all injuries.—JAMA, Vol. 193, No. 12, Sept. 20, 1965.

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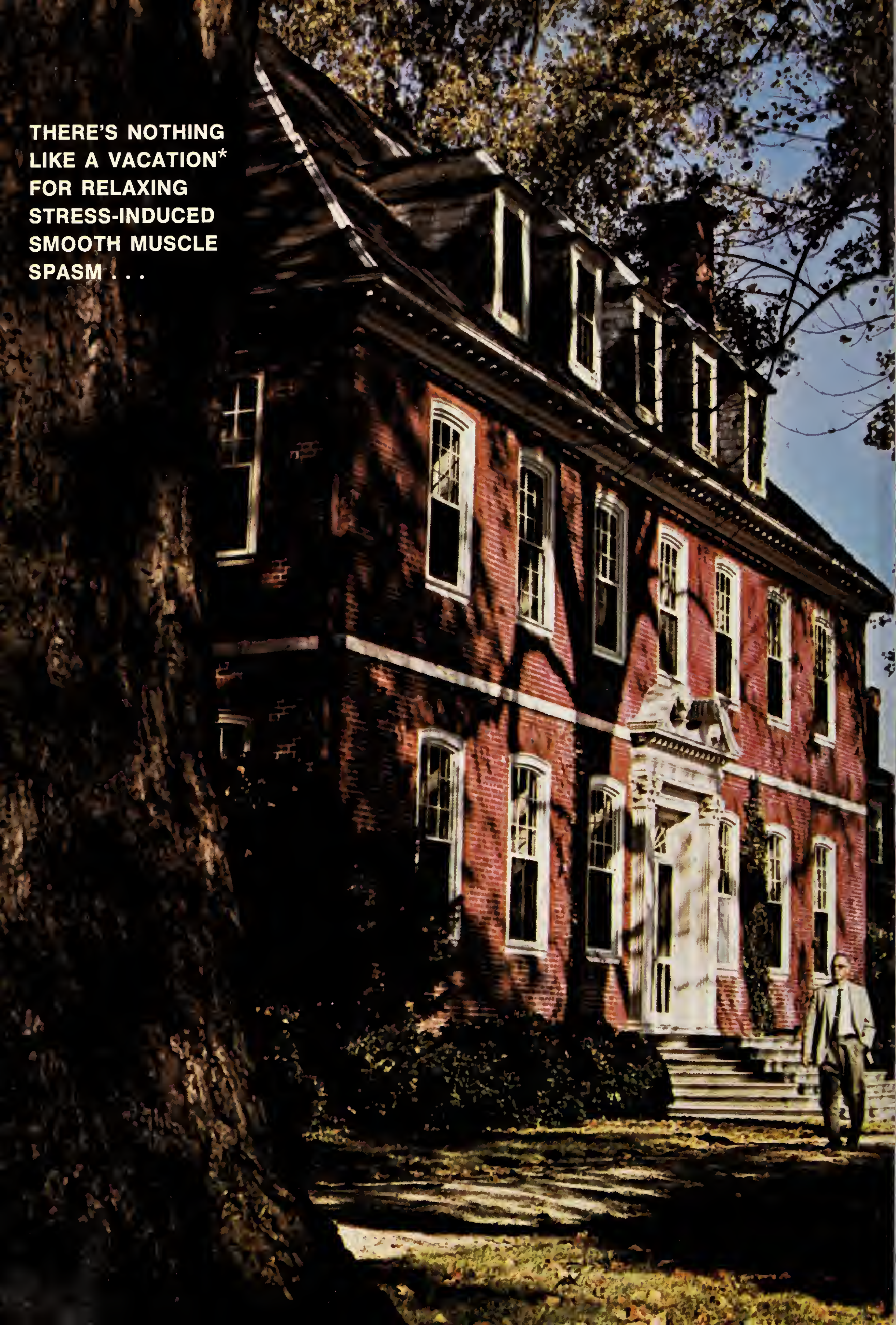
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t away from it all, there's nothing quite like Donnatal to relax
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REFERENCES: 1. Vollmer, H.: Arch. Neurol. and Psychiat., 43:1057, 1940. 2. Morrissey, J.H.: J. Urology, 57:635, 1947. 3. Krantz, J.C., Jr., and Carr, C.J.: Pharmacological Principles of Medical Practice, 2nd ed., Baltimore (1954), 552.

*This one at Westover, elegant Colonial Virginia plantation, located on the James River near Richmond. Built in the early 1730's by William Byrd II, founder of Richmond, it is now the home of Mrs. Bruce Crane Fisher.

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PERSONAL MENTION

Hugh T. Caumartin, M.D., Saginaw,
Hugh L. Sulfridge, M.D., Saginaw,
left Saginaw in April to serve two months in Viet Nam under the United States Inter-Voluntary Agencies for South Viet Nam, the American Medical Association and the Agency for International Development. They will join the 50 physicians already in Viet Nam treating and caring for the ill and injured civilians.

Robert C. Horn, Jr., M.D., Detroit,
will speak July 15-16 at the Annual Rocky Mountain Cancer Conference at Denver.

James Evans Kelly, M.D., Flint,
will participate on a panel on "a call for action" at the annual meeting April 13 in Flint of the Michigan League for Nursing.

John T. Keyes, M.D., Birch Run,
addressed the Bay City Rotary Club recently on "Sex Education; Bare Facts Are Not Enough."

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J. L. Leach, M.D., Flint,
is president-elect of the Michigan Academy General Practice, elected at the recent annu meeting. Doctor Leach has practiced in Fli for more than 45 years.

Carl French, M.D., Dundee,
who for more than 20 years served as the hi school team doctor, recently received a plaq of "sincere appreciation" for services re dered to the former high school athletes. T presentation was from the Dundee Viking Clu

Lawrence R. Banner, M.D., Kalamazoo,
Frederick C. Ryan, M.D., Kalamazoo,
are now members of the staff of Kalamaz State Hospital. They had practiced together Kalamazoo since 1946.

Ruth Preston, M.D., Detroit,
has been appointed by the Michigan Commi sion on Aging to a special committee to devi a plan to provide registered and practic nurses to meet demands, especially as t problem relates to the aging population.

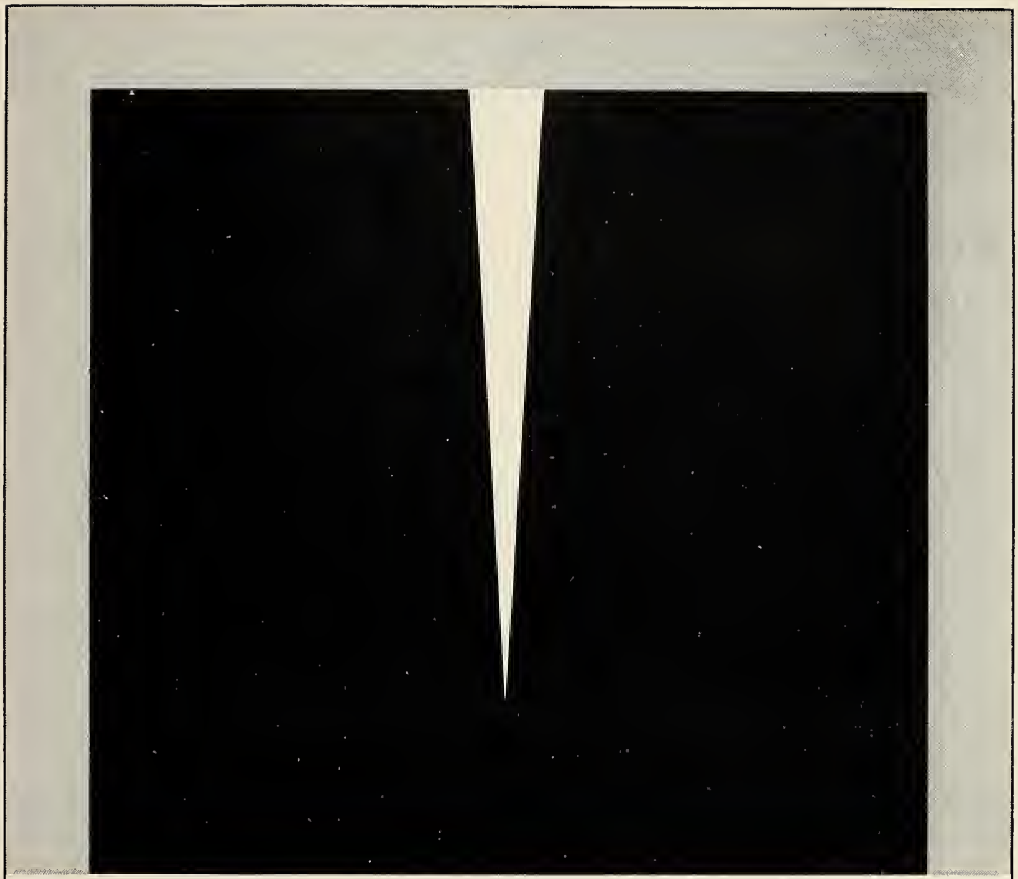
Gerald S. Weintraub, M.D., Detroit,
has been named assistant clinical director the Wayne State University Health Service. has been associated with the Service sin 1962.

John J. Hsu, M.D., Pontiac,
participated in a panel at Oakland Universi recently under the sponsorship of the Oakla County Community Mental Health Servic Board. The theme was "Working Together Better Serve Others."

Julia P. Brandeberry, of Lansing,
is the new Assistant Chief of Nursing Servic in the Division of Nursing, U. S. Public Heal Service. Miss Brandeberry will assist the Chi of the Division, Jessie M. Scott, to foreca needs for nursing, and to plan, assess, and c ordinate programs to improve the organizati and delivery of nursing services in institutio and public agencies. Miss Brandeberry h been with the Michigan Department of Publ Health, as chief, Section of Nursing.

Roger B. Nelson, M.D., Ann Arbor,
spoke at the Michigan Hospital Associati "Conference on the Hospital Public Relatio Aspects of Medicare" at the University Michigan, April 4.

Clara Raven, M.D., Detroit,
was recently selected by the Detroit Centr Business District Association as one of t "Ten Top Women of Detroit." Doctor Rave who retired as a Colonel in the Army Reserv last spring after 22 years of Army duty, is de uty medical examiner of Wayne County.



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From the Mailbag

Your Forum question for April interested me and I'd like to add some comments to the question of "Do you believe that hospital planning by law would become a brake or an incentive for innovation toward better quality and economy?"

One cannot live in today's society without becoming reconciled to, like it or not, increased legislation. Self-preservation has become a group affair.

I don't like legislation; it robs me of the challenge of self-determination. Every time a new law is passed in the name of humanity, I feel less human. Law by definition is restrictive.

But that's not the issue. We need laws. We need laws for birth control, expressway driving and hospital planning. The question is, Can we within the circumscribed limits of civilization still produce, deliver, create? I for one think we can. I also think, without law, we won't.

Freedom, paradoxically, cannot be defined today outside society. And a responsible society is one which plans, legislates and prescribes new areas for personal expression.

Very truly yours,
Roger W. DeBusk, M.D., *Director*
Grace Hospital, Detroit

The American Medical Association through its Registry on Adverse Reactions of the Council on Drugs is encouraging the wider reporting of drug reactions by physicians and hospitals. We are interested in obtaining unpublished data on serious, unusual, or unexpected reactions, even though such observations may be based only on suspicion or circumstantial evidence. Such data are essential if early alerting of the medical profession to unsuspected hazards of drugs is to be a reality.

We urge you to increase the input of reports to the Registry. Reports are evaluated and the results published as cautionary statements, articles, sun maries, tabulations and editorials on the potenti hazards and adverse reactions of drugs in JAM state journals, and specialty journals.

Additional information and report forms are avai able from the AMA Registry on Adverse Reaction Council on Drugs, American Medical Association, 5 North Dearborn Street, Chicago, Illinois 60610.

Sincerely,

F. J. L. Blasingame, M.D.
Executive Vice President
American Medical Associatio

The Michigan State Medical Society is to be con mended for their wonderful idea in coming up wi the Healthmobile. The mobile idea is tremendo because it gives all the people in Michigan an o portunity to see this wonderful exhibit.

As a Hospital Administrator I felt that the Healt mobile was most fascinating and very educational. believe that anyone visiting the Healthmobile wou be impressed with what we did not have years a and what we do have today.

As a citizen of Marlette, Michigan, we are pro of the Marlette Coach Company who made this m bile home possible.

Very truly yours,

Donald Shepherd, *Administrato*
Marlette Community Hospital,
Marlette

The presence of the Healthmobile at the Northla Center was an opportunity for Southfield Scho pupils and staff personnel to become well acquaint with the work of the Michigan State Medical Socie

All children are becoming health conscious and t project is of great educational value.

John W. English
Superintendent
Southfield Public Scho

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PSYCHIATRIC RESIDENCY: Several openings for July 1966, including one opening for a general practitioner or physicians in other specialties who are four years beyond their internship. Three-year approved psychoanalytically oriented program; a division of the Department of Psychiatry, Wayne State University, the program is staffed by full-time University faculty; offers both emergency in-patient service of 120 beds plus extensive adult and children's outpatient clinics with close supervision by staff and analytic consultants; active teaching, seminar and research programs. Stipend for General Practitioners, $12,000/yr., for General Psychiatric Residents, $7,516-$8,519. Contact: Kenneth Pitts, M.D., Clinical Director, Department of Psychiatry, Detroit General Hospital, 1151 Taylor, Detroit, Michigan 48202.

MEDICAL DIRECTOR for Tri-County Health Department. Population 112,000, located in lower central Michigan, requirements, M.D., M.P.H., salary range contingent on qualifications approximately $20,000. Direct inquiries to Charles A. Potter, Acting Director, Branch-Hillsdale District Health Department, 35 South Sprague Street, Coldwater, Michigan.

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Time for MAP Congress And Legislative Work

MAP's door latch is out. You're in!

May I personally urge you to participate in the Seventh Annual Congress of the Professions in Detroit, May 14-15.

The Congress door is open, whether you are a member of the Michigan Association of the Professions or not. Personally, I'm proud to be an active member, and enjoy serving on the MAP Board of Directors, along with G. B. Saltonstall, M.D., a MSMS past president, and D. Bruce Wiley, M.D., our MSMS Secretary.

Often the Madison-Avenue approach to conferences and conventions is tempting. The word-coining drum-beaters would describe the 1966 Congress at the Pontchartrain Hotel as:

"Something for the whole family," or

"Everything is new," or

"Weekend at the Pontchartrain," or

"Significant speakers with signposts."

To me, the names of the speakers and the subjects are more intriguing. Nationally-known authorities will cover the various aspects of our professional life—such as Legislative, Organizational, Scientific, Economic, Religious, Cultural, and Social. (See page 394 for program details.)

As a physician, I feel that it is imperative that we discuss vital issues with the men and women in the other professional fields, and to learn more about their hopes and concerns. The annual MAP convention permits us to do just that.

As an honorary chairman for the Seventh Annual Congress of the Professions, I can assure you that you will gain much by participating.

Remember, the MAP door latch is out for you, in Detroit, at the Pontchartrain, May 14-15.

Previously in my monthly message I have urged all of you to be more active community affairs and in good government. There are several bills in the Michig legislature of interest to the medical profession, and I would urge you to study t bills and develop your opinion about their merits. May is the ideal month to let yo legislator know your views—write to him, see him when he is home weekends, make an appointment to visit him in Lansing. As the days run out f consideration of bills, immediate action is needed. June 8 is the dea line for passage of the bills from the other house, and June 10 is sche uled as the beginning of the summer recess. Your assistance is solicite

Luther R. Leader M

JUNE, 1966 — PUBLISHED MONTHLY — MICHIGAN STATE MEDICAL SOCIETY

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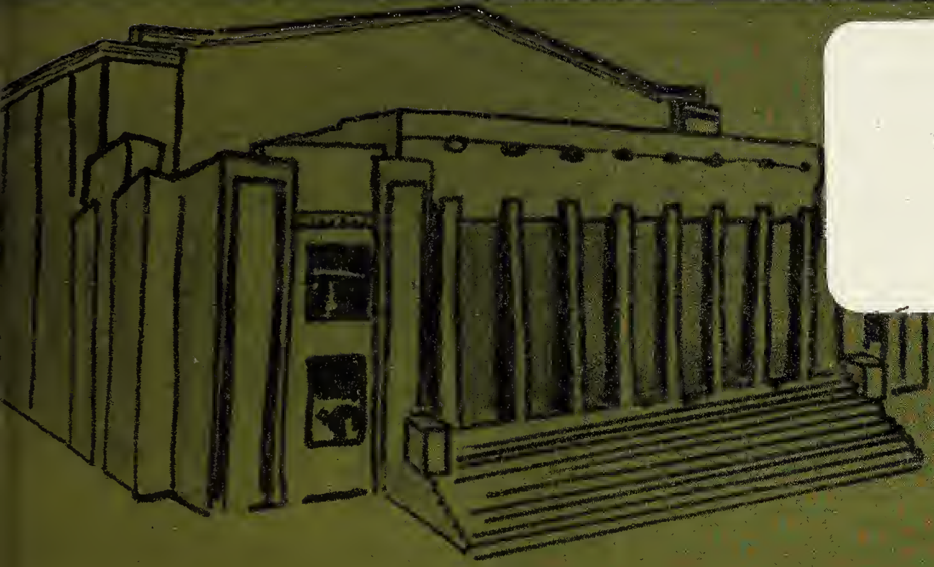

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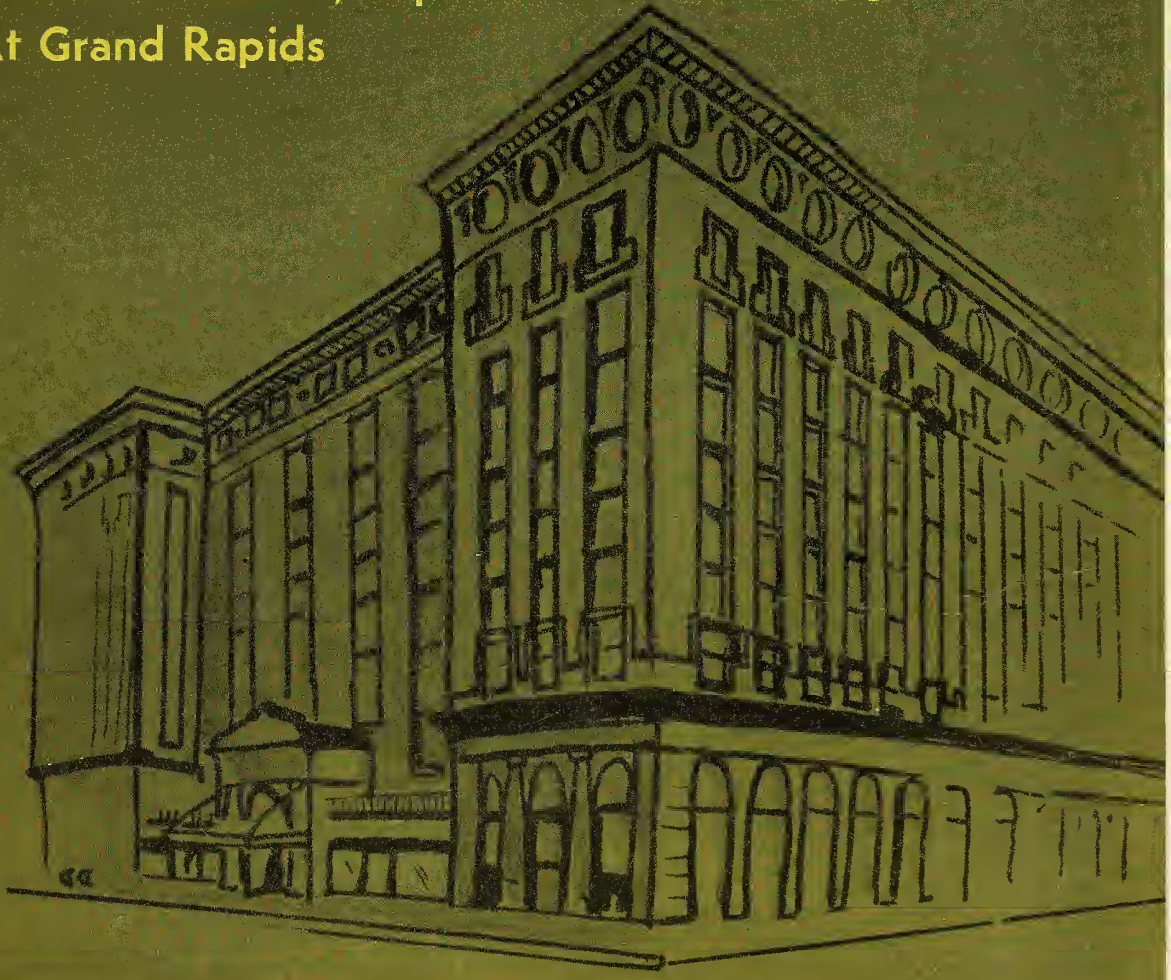

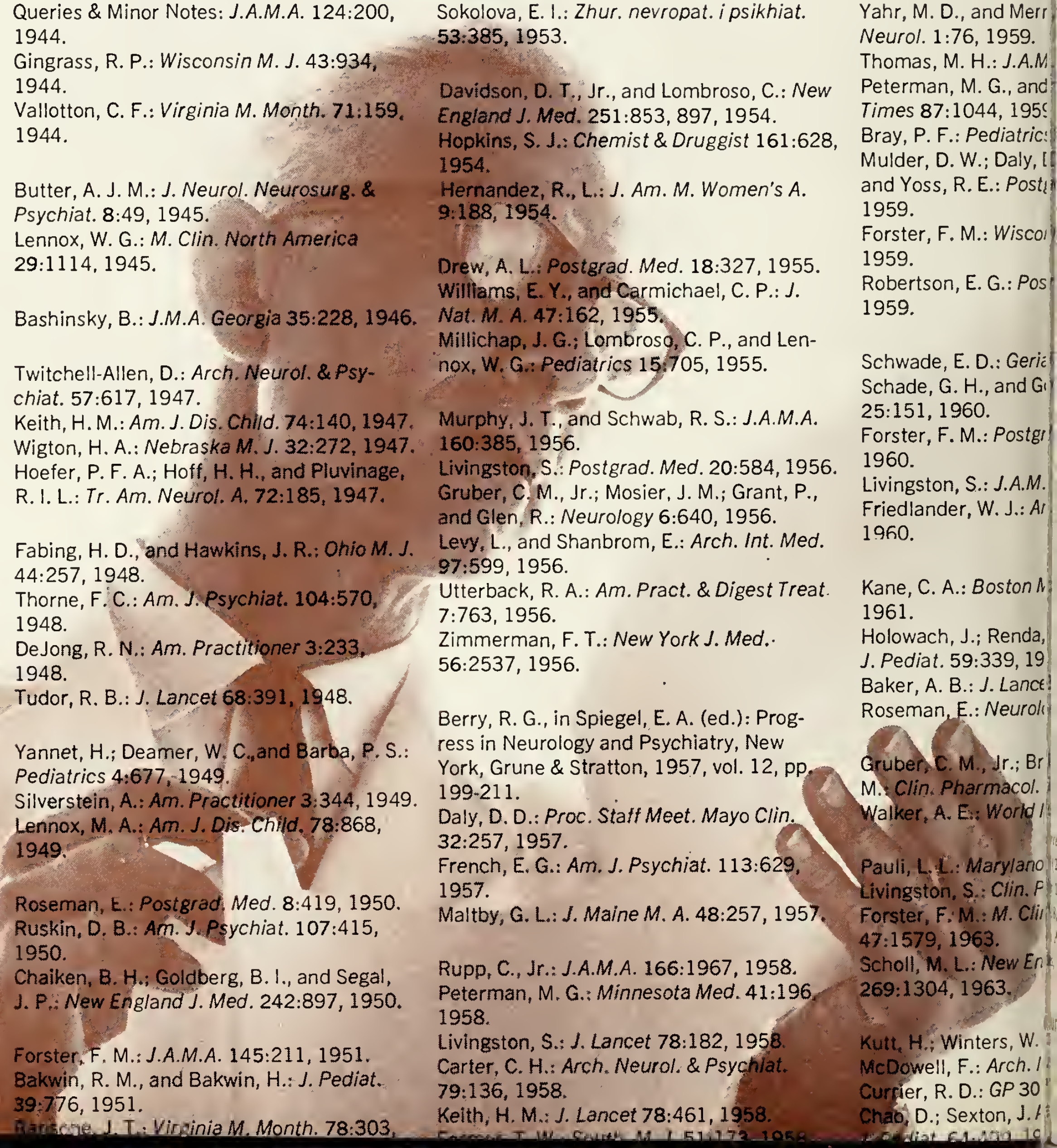

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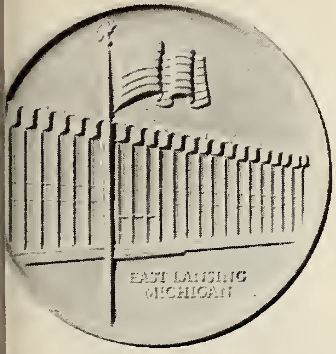

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ublished monthly, except two extra issues to be published in October and December, by the Michigan State Medical Society s official journal at 2642 University Ave., Saint Paul, Minn. 55114. Second class postage paid at Saint Paul, Minnesota. rly subscription rate, $9.00; single copies, 80 cents. Additional postage: Canada, $1.00 per year; Pan-American Union, 0 per year; Foreign, $2.50 per year. Printed in USA. All communications relative to manuscripts, advertising, news, exnges, etc., should be addressed to Publication Committee, Michigan State Medical Society, 120 West Saginaw Street, East sing, Michigan 48824. © 1966 Michigan State Medical Society.

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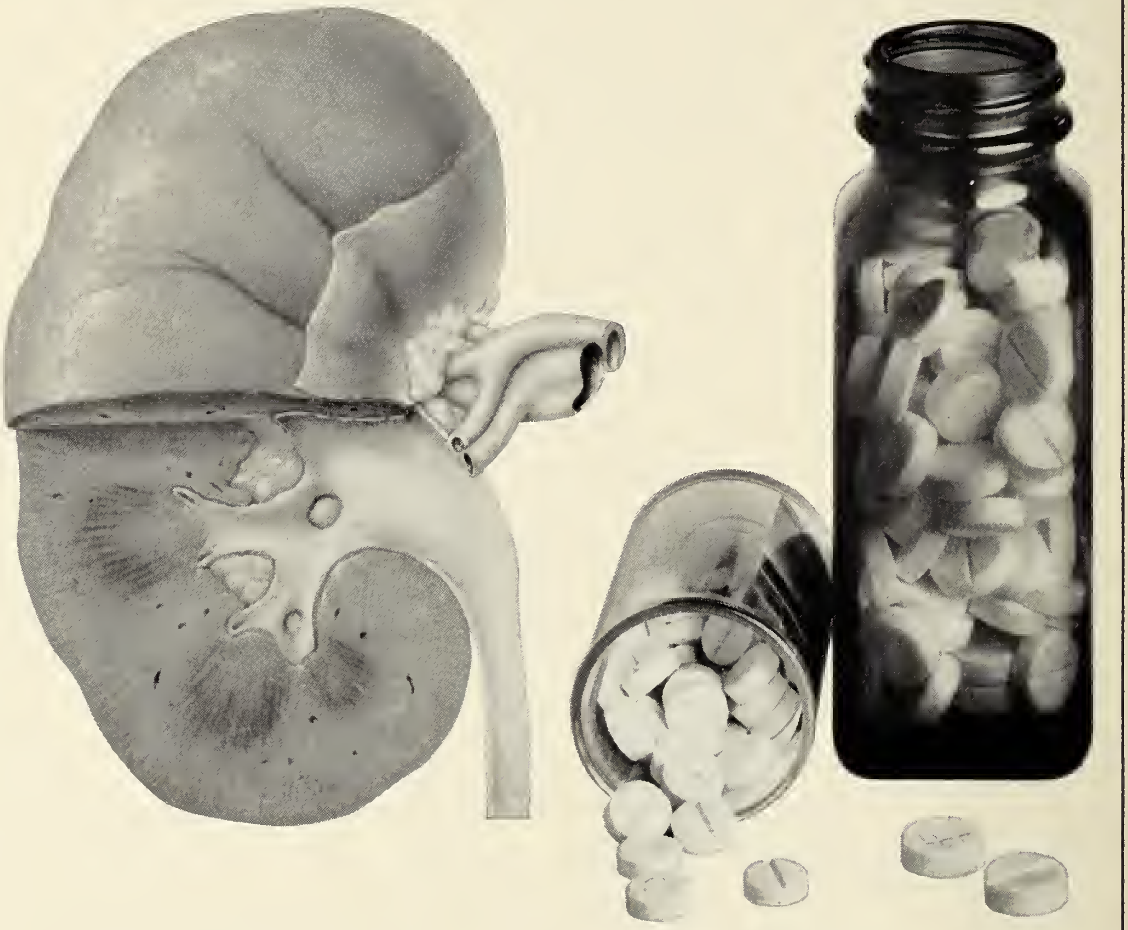

understanding... precedes development

The development of chlorothiazide and probenecid were events of major importance, but perhaps even more important for the future was the Renal Research Program by which they were developed. When Merck Sharp & Dohme organized this program in 1943, it was expressing in action some of its basic beliefs about research:

- Many problems connected with renal structure and function were still undefined or unsolved. The Renal Research Program would begin its basic research in some of these problem areas.
- From knowledge thus acquired might come clues to the development of new therapeutic agents of significant value to the physician.

For example, the Renal Research Program put fifteen years into this search before chlorothiazide became available. But because these years had first led to a greater understanding of basic problems, the desired criteria for chlorothiazide existed before the drug was developed.

Along with other research teams at Merck Sharp & Dohme, the Renal Research Program continues to add new understanding of basic problems—understanding which will lead to important new therapeutic agents.

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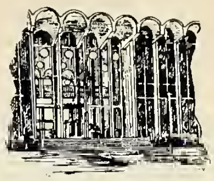

MA to Install
lichigan Native

Charles L. Hudson, M.D., of Cleveland and a na-
ve of Merrill, will be installed as president of the
MA at the Annual Convention in Chicago, June
-30.

Dctor Hudson, a graduate of Alma College and
e University of Michigan Medical School, will
cceed James Z. Appel, M.D., as the AMA pres-
ent.

An attendance of 45,000, including 15,000 physi-
ans, is expected at the AMA's 115th annual meet-
g. A diverse scientific program covering virtually
ery medical specialty will be presented.

The AMA's policy-making House of Delegates
ll meet in the Palmer House hotel, and more than
0 scientific exhibits will be housed in McCormick
ace convention center.

McCormick Place also will be the site of many
ientific sessions and an extensive medical motion
cture and television program. The telecasts will
iginate from the University of Illinois College of
edicine, University Hospitals, Chicago.

Topics of the six general scientific sessions include
nphysema, population expansion, burns, mysterious
vers, community hospitals and coronary care units,
d headaches.

octors Help Find
ledicare Eligibles

Michigan physicians are urged to help find the
imated 12 per cent of the eligible Michigan res-
ents who have not signed up for the medical insur-
ce option of Medicare.

"We believe the physicians can reach those who
ve not signed up because we know some older peo-
e who are difficult to reach through newspaper, ra-
o and television appeal," says MSMS President Lu-
er R. Leader, M.D., Detroit.

"We assume those we still must reach are the bed-
lden sick, the illiterate, the very old, and the very
lated."

The March 31 deadline for the Medicare option
ıs extended to May 31. Officials estimate that the
spitalization part of Medicare will cost about $2.3
lion in the first year of the program which starts
ly 1.

Benefit payments under Plan B, the medical part of
edicare, are estimated at $765 million for the first
ar.

Many Committees Advance Plans

The pace of MSMS committee work is picking up as committees move along projects and reports for the 1966 MSMS House of Delegates meeting in Grand Rapids.

Following is a list of the committees which have met since February 1: February—Awards Committee; Legal Affairs; Specialty Group; MD-PAC State Board; Mental Health; Liaison with Michigan Hospital Service; Nursing; Relative Value Study Unit; Medical Aspects of Organized Athletics; Public Relations; Medicine & Osteopathy. March—Governmental Medical Care; Alcoholics & Drug Addition; Iodized Salt; Legal Affairs; Statewide Medical Examiners; Procedures; Ophthalmology. April—Professional Insurance; Rural Medical Service, Nursing; Medicine & Religion; Education Liaison and Paramedical Education; Uniform Fee Schedule; Governmental Medical Care Program; Hospital Relations; Medical Doctors and Doctors of Osteopathy; Public Health; Michigan's Outstanding Physician; Cardiac Disease; Judicial Commission. May—Committee on Certificates of Commendation; Heart-Cancer-Stroke; Medical Socio-Economics; Evaluation Prepaid Medical Services; Rehabilitation.

Urge Greater Protection Against Measles

The Council has issued an appeal to all physicians to continue its efforts to provide measles immunization to their patients. The Council urges that the measles immunizing material be handled in the same manner as have other immunizing agents in the past.

MSMS attracted considerable attention last year when it conducted a six-week campaign to push measles vaccine. Billboards, bus signs, newspaper articles, television films, et al., were effectively used.

The campaign caught the eye of physicians in Ohio, and the Ohio State Medical Society recently conducted such a campaign, using many of the MSMS time-tested activities.

One of the busiest MSMS committees is a new one created by Resolution 35 of the 1965 MSMS House of Delegates. The new Governmental Medical Care Programs Committee was given five specific duties including "to represent MSMS in all matters concerning the Medicare programs." A. J. Neerken, M.D., Kalamazoo, fourth from the left, is the committee chairman. Shown at a Committee meeting at the MSMS headquarters, left to right, are Herbert Mehler, staff member in charge of governmental medical care programs; F. C. Brace, M.D., Grand Rapids; J. C. Benson, M.D., Flint; Doctor Neerken; Otto K. Engelke, M.D., Ann Arbor, and R. L. Mainwaring, M.D., Dearborn. Also on the Committee are W. H. Huron, M.D., Iron Mountain; T. V. Kretschmer, M.D., Saginaw; P. T. Lahti, M.D., Royal Oak, and D. N. Sweeny, Jr., M.D., Detroit.

Associations Serve Two Major Functions

The wide variation of activities carried on by the 18,000 associations in the United States underscores two basic values and functions of the associations in America's economy and society.

First, they provide a means of experience sharing by individuals and entities engaged in the same activity or having a common interest. The benefits of this shared experience accrue democratically to all members, large and small, and might otherwise be unobtainable.

Second, they make possible—through voluntary, cooperative support — beneficial programs that in most instances could not be undertaken by individual companies or persons. Many medical, engineering, scientific, technological and social advances affecting the lives of all Americans exist only because of such programs.

Quoted from
"Association Public Relations"
Public Relations Association of
America

WILEY RESIGNS AS MSMS SECRETARY

D. Bruce Wiley, M.D., Secretary of MSMS for th past five years and a former Chairman of The Cou cil, has resigned from The Council. He offered h resignation to The Council and explained that h was ending his private practice in Utica to join th Michigan Department of Public Health.

Doctor Wiley closed his office May 1 at Utica whe he had practiced since 1929. For many years, he wa the delegate from the Macomb County Medical S ciety to MSMS and served 10 years as Councilor fro the Macomb-Oakland district.

The Michigan Department of Public Health ha been designated as the administrative agency f Medicare in Michigan. Doctor Wiley will serve as member of the Division of Patient Services.

Smoking Linked

Among 250,000 U. S. veterans observed for mo than eight years of a 10-year study by U.S.P.H.S smokers continued to have a higher death rate tha non-smokers. In the same age group, 11 times many cigarette smokers as non-smokers died of lu cancer, and 12 times as many died of emphysem Three or more times as many died of cancer of t mouth, pharynx, esophagus or larynx, and from su diseases as bronchitis, asthma, stomach ulcer, du denal ulcer and non-syphilitic aneurysm of the aort The mortality risk was shown to be related to t amount smoked for each form of tobacco use.

Results to date from the study begun in 1954 a reported in a monograph "Epidemiological Studies Cancer and Other Chronic Diseases," recently pu lished by the National Cancer Institute.

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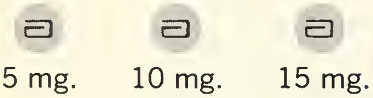

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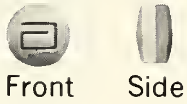
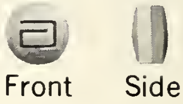
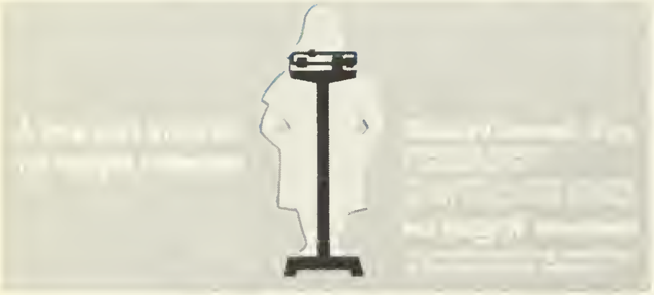


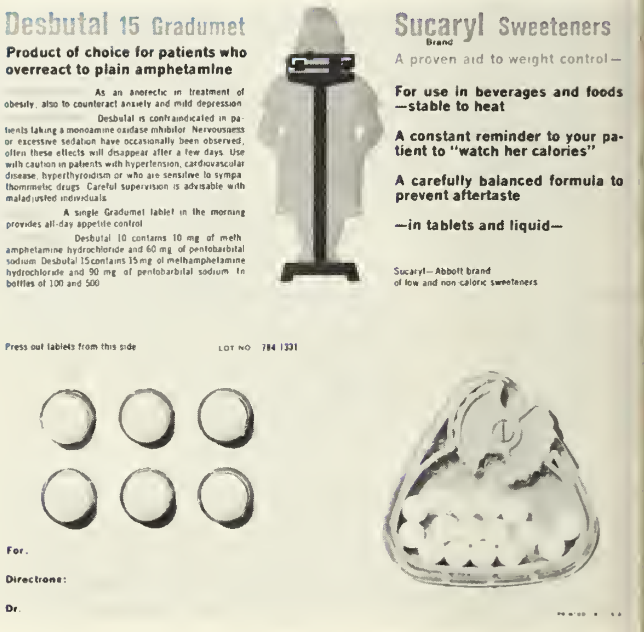
DESBUTAL 15 Gradumet
15 mg. Methamphetamine Hydrochloride,
90 mg. Pentobarbital Sodium



samples available



Each sample contains 6 tablets and a filled Sucaryl® Sweetener dispenser. For a supply, write Abbott Laboratories or ask your Abbott man.



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As an anorectic in treatment of obesity, also to counteract anxiety and mild depression

Desbutal is contraindicated in patients taking a monoamine oxidase inhibitor. Nervousness or excessive sedation have occasionally been observed, often these effects will disappear after a few days. Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism or who are sensitive to sympathomimetic drugs. Careful supervision is advisable with maladjusted individuals.

A single Gradumet tablet in the morning provides all-day appetite control.

Desbutal 10 contains 10 mg. of methamphetamine hydrochloride and 60 mg. of pentobarbital sodium. Desbutal 15 contains 15 mg. of methamphetamine hydrochloride and 90 mg. of pentobarbital sodium. In bottles of 100 and 500.

Press out tablets from this side   LOT NO 784 1331

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A constant reminder to your patient to "watch her calories"

A carefully balanced formula to prevent aftertaste

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of low and non-caloric sweeteners

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Patients, in many cases, save enough to get five weeks of medication for the price of four, compared to other leading long-release anorectics.

CONTRAINDICATION: Desoxyn and Desbutal are contraindicated in patients taking a monoamine oxidase inhibitor.
PRECAUTIONS: Use with caution in patients with hypertension, cardiovascular disease, hyperthyroidism, old age, or those sensitive to sympathomimetic drugs or ephedrine and its derivatives. Careful supervision is advisable with maladjusted individuals.

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Welcome, New Members

Roger M. Ajluni, M.D., 13345 W. McNichols Rd., Detroit 35, Michigan

Charles R. Alvey, M.D., 3001 Miller Rd., Dearborn, Michigan

Robert G. Ause, M.D., 1821 Sheridan, Ann Arbor, Michigan *(Roentgenology & Radiology)*

John R. Bartone, M.D., 217 S. Madison, Traverse City, Michigan *(Neurosurgery)*

Donald Brown, M.D., Henry Ford Hospital, Detroit, Michigan, 48202 *(Internal Medicine)*

Eugene N. Chardoul, M.D., 202 Paterson Bldg., Flint, Michigan *(Internal Medicine)*

Robert H. Chesky, M.D., Herman Kiefer Hospital, Detroit, Michigan

John Colombo, M.D., 20927 Kelly Rd., East Detroit, Michigan *(Ophthalmology)*

Donald P. Didelius, M.D., University Medical Center, Ann Arbor, Michigan *(Orthopedic Surgery)*

arl M. Hasegawa, M.D., 1400 Chrysler Expwy., Detroit, Michigan 48207

Marjorie J. Hickman, M.D., 147 Viking Court, Battle Creek, Michigan *(Internal Medicine)*

Alan C. Hymes, M.D., VA Hospital, Dearborn, Michigan

Pliny M. Keep, M.D., 1521 Gull Rd., Kalamazoo, Michigan

Clemens M. Kopp, M.D., 205 N. East Avenue, Jackson, Michigan 49201 *(Pathology)*

arl E. Kuntzman, M.D., 260 Eastland Center Prof. Bldg., Harper Woods, Michigan *(Surgery)*

Philip J. LaFata, M.D., 15260 Levan Rd., Livonia, Michigan *(Surgery)*

Frank Lanuti, M.D., 147 Viking Court, Battle Creek, Michigan *(Surgery)*

Lloyd A. LeZotte, M.D., Upjohn Clinic, State Prison of Southern Michigan, 4000 Cooper, Jackson, Michigan *(Internal Medicine)*

Bernard Mandelbaum, M.D., 1400 Chrysler Expwy., Detroit, Michigan, 48207

Telesford A. Mascarin, M.D., 18101 E. Warren, Detroit, Michigan 48224

Richard C. Merriman, M.D., 516 Whites Rd., Kalamazoo, Michigan

John J. Minster, M.D., 314 S. Brown St., Mt. Pleasant, Michigan *(Surgery)*

Alan L. Morgan, M.D., 3169 W. Pierson Rd., Flint, Michigan *(Surgery)*

Nicholas Newton, M.D., 29901 Ford Rd., Garden City, Michigan

Richard D. Nichols, M.D., 1822 Pontiac, Ann Arbor, Michigan *(Otology, Laryn, Rhin)*

Bruce R. Ohmart, M.D., 2150 Iroquois Avenue, Detroit, Michigan 48214 *(Orthopedic Surgery)*

William R. Patterson, M.D., 2851 Canterbury Rd., Ann Arbor, Michigan *(Orthopedic Surgery)*

Herbert A. Ravin, M.D., 6767 W. Outer Drive, Detroit, Michigan 48235 *(Neurology)*

Richard C. Relken, M.D., St. Joseph Mercy Hospital, Pontiac, Michigan 48053

Frederick A. Salamon, M.D., St. Johns Hospital, Detroit, Michigan 48236 *(Roentgenology, Radiology)*

Allen Silbergleit, M.D., 1400 Chrysler Expwy., Detroit, Michigan 48207

Rodrigo R. Tobar, M.D., Maybury Sanatorium, Northville, Michigan *(General Practice)*

Virgilio Villarreal, M.D., 3917 Kellar St., Flint, Michigan *(Surgery)*

As MSMS members look forward to their 101st Annual Scientific Meeting in Grand Rapids, September 27-29, it can be pointed out that about 100 years ago the repeating rifle came into being. Oliver Winchester set up shop 100 years ago, and soon the repeating rifle became the "extra arm" of the settler, cowboy, soldier and hunter.

Just as Winchester introduced the Model 12 shotgun in 1912, etc., MSMS has improved its annual meetings greatly since the first one a century ago.

Abstract of MSMS Council Action

Meeting of April 20, 1966

UTILIZATION REVIEW COORDINATING COMMITTEE

The Council recommended that a Utilization Review Coordinating Committee be formed, consisting o representatives of MSMS, the Michigan Department of Health, Michigan Medical Service and Michigan Hospita Service, to inform each other on matters of utilization review responsibility under the Medicare law. B. C Payne, M.D., was named as MSMS representative.

DIFFERENTIAL FEE FOR GENERALIST AND SPECIALIST

Existing MSMS policy was reaffirmed, that there shall be no dual fee principle or different RVS conversio factor for generalist and specialist, and that all reimbursements for service remain on a fee-for-service basis.

MEDICARE PHYSICIAN PAYMENT GUIDELINE

The Council approved a recommendation that the 1965 RVS with a $5 conversion factor be used as a guideline for physicians payment under Medicare (Titles XVIII and XIX).

It further reaffirmed the absolute necessity of annual review of both the Relative Value Scale and the conversion factor.

In addition, The Council recommended that, under Public Act 89-97, every physician deal directly with th patient in both medical service and reimbursement, and that every physician should submit to the patient hi own charges based on his usual, customary and reasonable fees.

COMPLEMENTARY COVERAGE OFFERING TO BLUE CROSS-BLUE SHIELD SUBSCRIBERS OVER 65 I MSMS GROUP

The Council recommended that the over-65 in the MSMS group be offered the high level benefit coverag to complement the Medicare program.

MEETING WITH MICHIGAN UNITED FUND

The Council authorized a delegation to meet with representatives of the Michigan United Fund to discus matters of mutual interest.

STAFF FOR MSMS REGIONAL OFFICE

The Council authorized the employment of Mr. Peter Hoheisel as Assistant, public relations staff, for th Regional Office; and also agreed to inquire into the availability of a special consultant.

HEALTH MANPOWER STUDY

MSMS will take the initiative to call together the various groups within the state which are carrying ou studies of health manpower needs, with a view to reviewing common interests, avoiding duplication of effort an gaining coordination of subsequent efforts.

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Plainwell, Michigan—MU 5-8441

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M. Leroy Barry, M.D.

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- Medico-Legal counsel.
- Diagnostic and psychological evaluation and hospitalization, if indicated, of juveniles for Probate and Juvenile Courts.

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Soyalac satisfies the infant. Strikingly similar to mother's milk, it provides protein of high biologic value and balanced nutrients. Clinical data furnish evidence of Soyalac's excellence in promoting normal growth and development.

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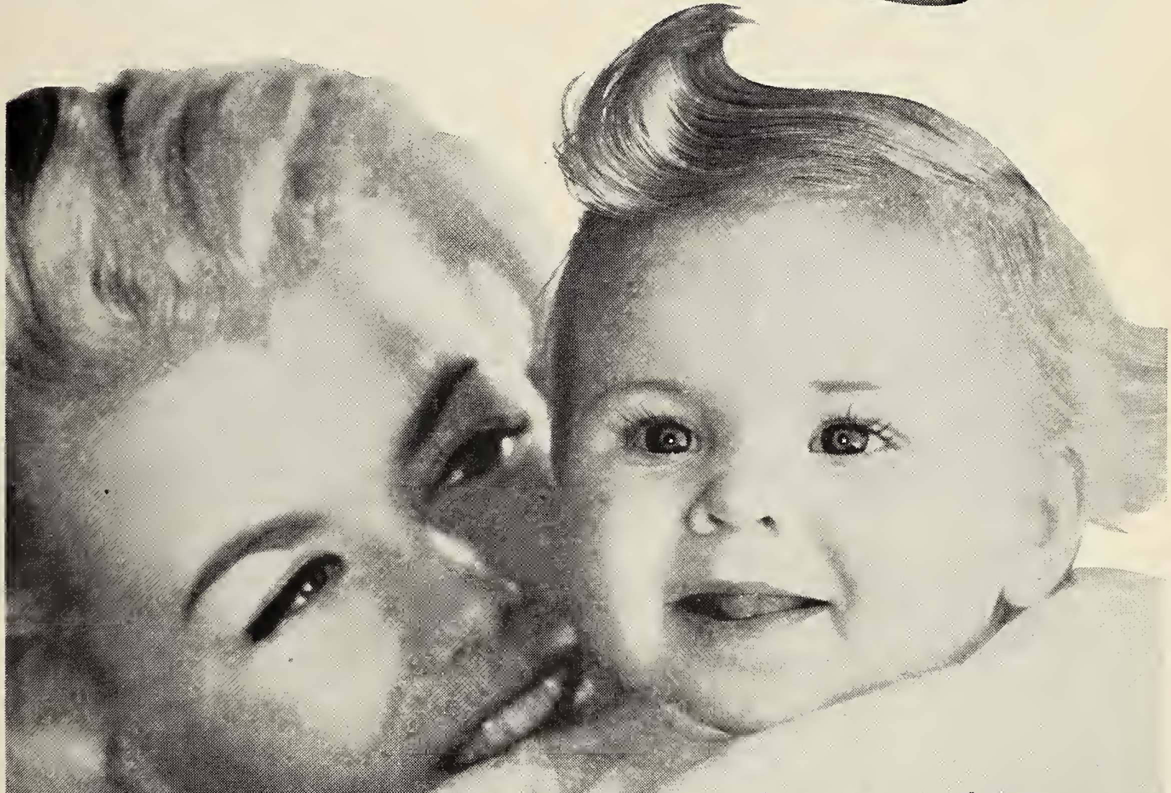

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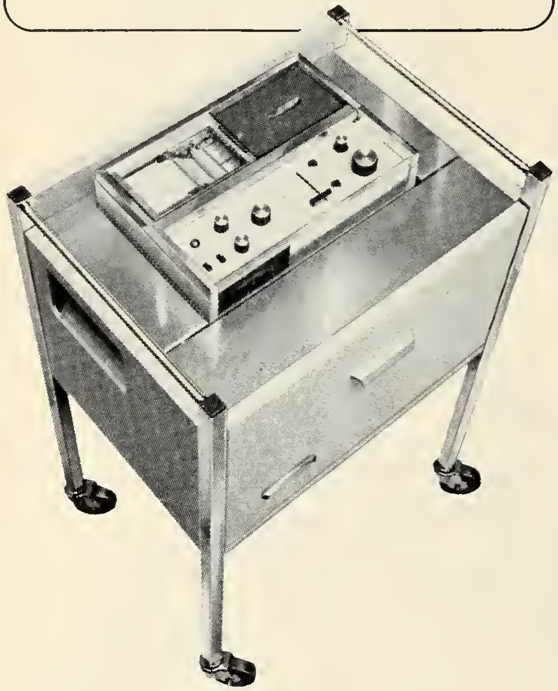

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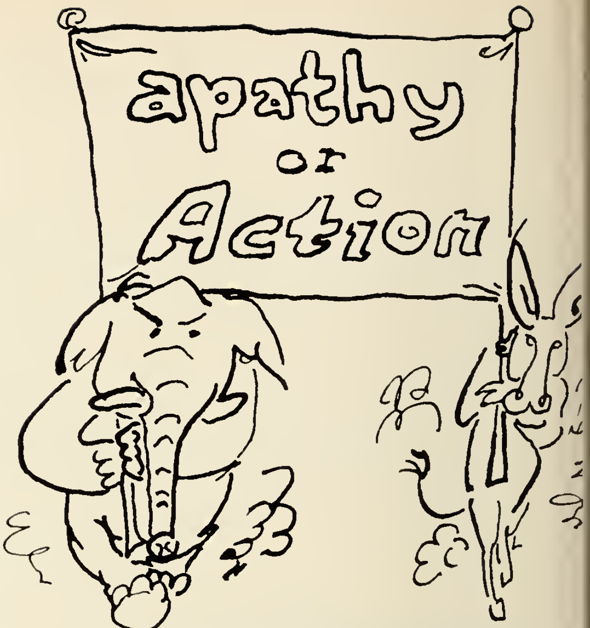

Political Laryngitis

"So many professional people who are willing
work for the Community Chest or the Heart Fu
refuse to participate in the political life of their co
munity. They act as if politics will go away if th
neglect it. But whether you like politics or not, y
are in it."

U. S. Senator Hugh Sc
Pennsylvania

Michigan voters this fall will select the following:

—U. S. Senator
—19 Congressmen
—Governor and Lieutenant Governor
—Secretary of State
—Attorney General
—38 State Senators
—110 State Representatives
—2 Supreme Court Justices
—2 to Michigan Board of Education
—2 to University of Michigan
  Board of Regents
—2 to Michigan State University
  Board of Trustees
—2 to Wayne State University
  Board of Governors

STUDY BONE TUMORS

David C. Dahlin, M.D., Mayo Clinic, was gue
discussant at the recent Michigan Society of Pathol
gists meeting at Hurley Hospital, Flint. Dr. Dahl
discussed a series of tumors of bone, presented as
slide seminar. The previous evening Dr. Dahl
spoke to the Michigan Pathologists on the topic
irradiation sensitivity or resistance of tumors of bon
Dr. Dahlin is an authority on bone tumors.

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An eminent role in medical practice

- Clinicians throughout the world consider meprobamate a therapeutic standard in the management of anxiety and tension.
- The high safety-efficacy ratio of 'Miltown' has been demonstrated by more than a decade of clinical use.

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(meprobamate)

Indications: 'Miltown' (meprobamate) is effective in relief of anxiety and tension states. Also as adjunctive therapy when anxiety may be a causative or otherwise disturbing factor. Although not a hypnotic, 'Miltown' fosters normal sleep through both its antianxiety and muscle-relaxant properties.

Contraindications: Previous allergic or idiosyncratic reactions to meprobamate or meprobamate-containing drugs.

Precautions: Careful supervision of dose and amounts prescribed is advised. Consider possibility of dependence, particularly in patients with history of drug or alcohol addiction; withdraw gradually after use for weeks or months at excessive dosage. Abrupt withdrawal may precipitate recurrence of preexisting symptoms, or withdrawal reactions including, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, the dose should be reduced and operation of motor vehicles or machinery or other activity requiring alertness should be avoided if these symptoms are present. Effects of excessive alcohol may possibly be increased by meprobamate. Grand mal seizures may be precipitated in persons suffering from both grand and petit mal. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side effects: Drowsiness may occur and, rarely, ataxia, usually controlled by decreasing the dose. Allergic or idiosyncratic reactions are rare, generally developing after one to four doses. Mild reactions are characterized by an urticarial or erythematous, maculopapular rash. Acute nonthrombocytopenic purpura with peripheral edema and fever, transient leukopenia, and a single case of fatal bullous dermatitis after administration of meprobamate and prednisolone have been reported. More severe and very rare cases of hypersensitivity may produce fever, chills, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, anaphylaxis, stomatitis and proctitis. Treatment should be symptomatic in such cases, and the drug should not be reinstituted. Isolated cases of agranulocytosis, thrombocytopenic purpura, and a single fatal instance of aplastic anemia have been reported, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity has been reported, usually after excessive meprobamate dosage. Suicidal attempts may produce lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse.

Usual adult dosage: One or two 400 mg. tablets three times daily. Doses above 2400 mg. daily are not recommended.

Supplied: In two strengths: 400 mg. scored tablets and 200 mg. coated tablets.

Before prescribing, consult package circular.

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In Memoriam

Ulysses Simpson Bagley, M.D., Saginaw

Ulysses S. Bagley, M.D., Saginaw physician, died March 27 at Saginaw General Hospital. He was 64.

A native of Longview, Texas, Doctor Bagley received his medical degree from Howard University Medical School, Washington, D.C. After interning at Freedman Hospital in Washington, Doctor Bagley practiced medicine in Lansing before going to Saginaw in 1932.

Doctor Bagley was a retired member of the Michigan State Medical Society.

Oscar H. Bruegel, M.D., Traverse City

Oscar H. Bruegel, M.D., 88, Past President of the Ingham County Medical Society, died April 28 at Traverse City where he retired in 1949.

Born in Manchester, Doctor Bruegel was graduated from the University of Michigan Medical School in 1902 and practiced medicine in the Lansing area for 46 years. He was active in the organization of the Ingham County Tuberculosis Sanatorium and was medical director there from 1919 to 1925. Doctor Bruegel was a member of the medical staff at Sparrow Hospital at its inception and was its chief of staff in 1923 and from 1931 to 1938, and helped organize the nurses training program at that hospital.

Doctor Bruegel was health officer of East Lansing for many years. During World War I Doctor Bruegel served as medical examiner for selective service.

Doctor Bruegel was a Life Member of the Michigan State Medical Society.

Thomas H. Chapman, M.D., Detroit

Thomas H. Chapman, M.D., Detroit physician for 12 years, died May 3 at his residence in Birmingham. He was 49.

A graduate of the University of Pennsylvania Medical School in 1954, Doctor Chapman practiced as a full-time specialist in internal medicine. He was affiliated with Grace and Mt. Carmel Mercy Hospitals in Detroit.

His wife, Katheryn L., is a doctor of medicine.

Samuel Glassman, M.D., Detroit

Samuel Glassman, M.D., founder of the Detroit Industrial Clinic, died April 3 in Miami, Florida, where he retired eight years ago. He was 83.

Born in Austria, Doctor Glassman was graduated from the Bellevue Hospital Medical School, Ne York, in 1908. He interned at Morgan Memorial Ho pital and St. Marks Hospital in New York and wa a pioneer in physical therapy in its application for r habilitation of the injured. Doctor Glassman wa engaged in the practice of traumatic surgery for ove 50 years. He was a member of the Detroit Academ for the Surgery of Trauma, the American Jewis Physicians Committee and the American Geriatri Society.

During World War I Doctor Glassman served in th Medical Corps.

Doctor Glassman received the Fifty Year Awar of the Michigan State Medical Society in 1958, an was a Life Member of that organization.

John Whitlock Gordon, M.D., Detroit

John Whitlock Gordon, M.D., Detroit physician an surgeon, died April 27 at his residence. He was 74.

A graduate of the University of Cincinnati Medica College in 1917, Doctor Gordon specialized in obste rics and gynecology. He was affiliated with Woman Hospital, Detroit. Doctor Gordon was a Fellow o the American College of Surgeons, a member of th Michigan Obstetrical and Gynecological Society, th Detroit Academy of Surgery and Nu Sigma Nu med ical fraternity.

A first lieutenant in World War I, Doctor Gordo was a member of the Disabled American Veteran and served as a captain in the Michigan Nationa Guard from 1920 to 1925.

Doctor Gordon was a retired member of the Michigan State Medical Society.

Robert I. Greenidge, M.D., Detroit

Robert I. Greenidge, M.D., 77, retired Detroi physician, died May 4 at Grace Hospital.

A native of Georgetown, British Guiana, Docto Greenidge was graduated from the Wayne State Uni versity School of Medicine in 1915 and was grante a golden anniversary award from that school in 196 Doctor Greenidge took postgraduate work in x-ray a Cook County Hospital, Chicago, and at the Illinoi Postgraduate Hospital. His memberships included th American College of Radiology, Alpha Phi Alph Medical Fraternity and the National Medical Asso ciation. He founded Fairview Sanitarium and th East Side Medical Laboratory, the latter of which h was also a director.

Doctor Greenidge was a Life Member of the Mich

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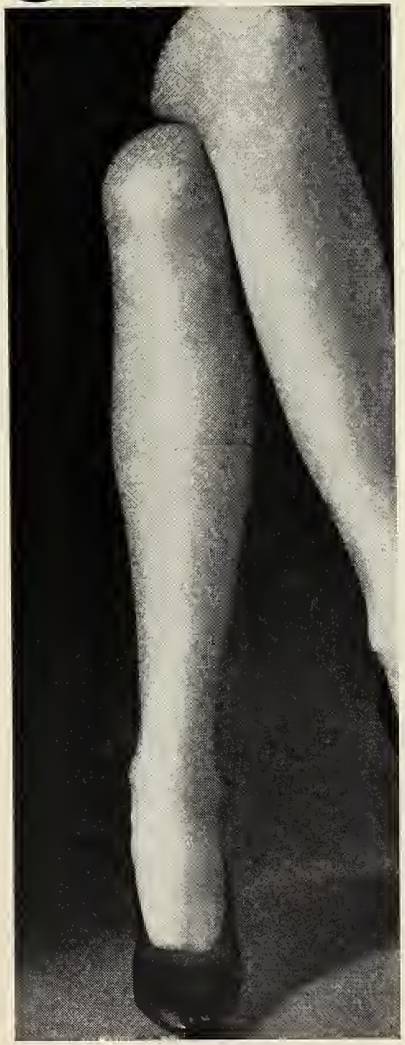
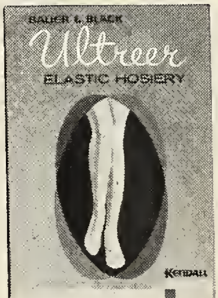


Elastic Stockings so sheer they look like support hose. Both Ultreer and support hose are sheer, shapely, cool and comfortable. But that's where the similarities end. New Ultreer fits firmly and evenly over the entire leg. Gives true therapeutic compression necessary to relieve varicose veins and other leg disorders. They provide the therapy you prescribe. The fashion and economy she demands.
Ultreer stockings have a new low price. So low, she can afford two pairs of Ultreer instead of one pair of regular elastic stockings. There'll be no disagreements there. Ultreer stockings are as comforting to her purse as they are to her legs. New Ultreer are the elastic stockings doctors and women can agree on.



KENDALL
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IN MEMORIAM/Continued

igan State Medical Society and received its 50 Year Award at the Centennial Session in 1965.

Ervin F. Kercher, M.D., Kalamazoo

Ervin F. Kercher, M.D., pediatrician from Kalamazoo, died April 24 at age 41.

A graduate of the University of Michigan School of Medicine in 1951, Doctor Kercher practiced his specialty in pediatrics in Kalamazoo since 1955. He was a member of the American Academy of Pediatrics and Alpha Kappa Kappa Medical Fraternity. Doctor Kercher's hospital affiliations were Bronson Methodist Hospital and Borgess Hospital, Kalamazoo.

During World War II Doctor Kercher saw active duty in the U.S. Naval Reserve during 1943-1946.

Harry J. Prall, M.D., Lansing

Harry J. Prall, M.D., 73, Lansing general practitioner, died April 5.

A former Pontiac resident, Doctor Prall was graduated from the University of Michigan School of Medicine in 1918. His hospital affiliations included Sparrow and St. Lawrence, Lansing, and he was a member of Phi Chi Medical Fraternity. In the past he served as secretary to the Eaton County Medical Society.

During World War I Doctor Prall served in the U.S. Navy Reserve.

George F. Schlacht, M.D., Romulus

George F. Schlacht, M.D., General practitioner from Romulus, died April 9 in Houston, Texas, after undergoing surgery there. He was 59.

A graduate of Wayne State University School of Medicine, Doctor Schlacht practiced in Romulus for 30 years. Doctor Schlacht's hospital affiliations included Annapolis at Wayne, Outer Drive at Lincoln Park, Beyer at Ypsilanti and Seaway at Trenton.

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spring 1966

DORSEY Season

A journal within a journal published quarterly in the interests of better medicine by Dorsey Laboratories, a division of The Wander Company, Lincoln, Nebraska. Address communications to Raymond C. Pogge, M. D., Director of Medicine.

Duodenal mucosa with ulcer crater—Approx. 80× Magnification.

Loosening epithelial cells of nasal mucosa during early stage of cold—Approx. 1800× Magnification.

this issue: partners in misery

partners in misery: common cold and duodenal ulcer*

a century or two ago our forefathers believed that the common cold was caused by an excess of evil humors. Today we regard these baleful humors as a result of the cold rather than its cause. Only in the last ten years have some of the offending viruses been cultivated, and we now know many others can be transmitted to human volunteers although they cannot yet be grown in the laboratory. Various body defenses react to infection by a virus, and in the respiratory tract the lung is protected by the phagocytic properties of the pulmonary alveolar macrophage.[1]

Because of the brief history and large proportion of unidentified viruses, effective prophylactic vaccines have not yet appeared. A universal antiviral agent seems even more remote. Meanwhile, these viruses continue to produce epidemics of upper respiratory infection at seasonal intervals, particularly in spring, fall and winter, during which they propagate and distribute progeny indiscriminately. As a result, they are responsible for significant work loss. Since the immunity afforded is temporary, recurrent infections are common.

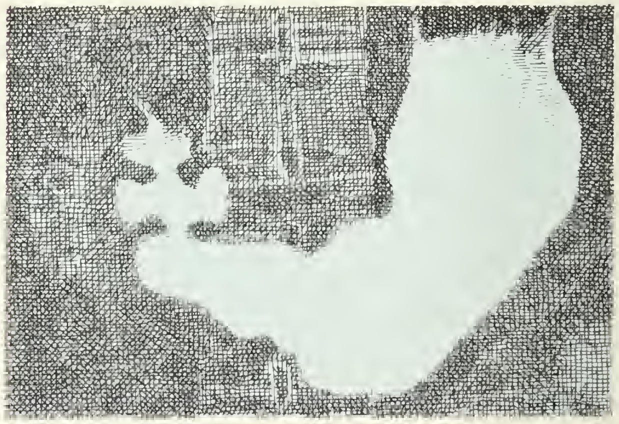
This recurrent morbidity in spring and fall is shared by duodenal ulcer, itself a cause of significant loss in wages and medical expense. Thirty years ago Emery and Monroe reported 1,279 recurrences of peptic ulcer of which 13 per cent could be attributed to upper respiratory infection, thus confirming a long-held clinical impression.[2] While the inflammation, congestion and secretion of the mucosa of the nasopharynx in the common cold, and the hyperemia and hypersecretion of the gastric mucosa during acute exacerbation of a duodenal ulcer may not be directly linked, it is probable that the miseries of the infection are reflected in the pain of the ulcer. The following case history illustrates this point.

Case report

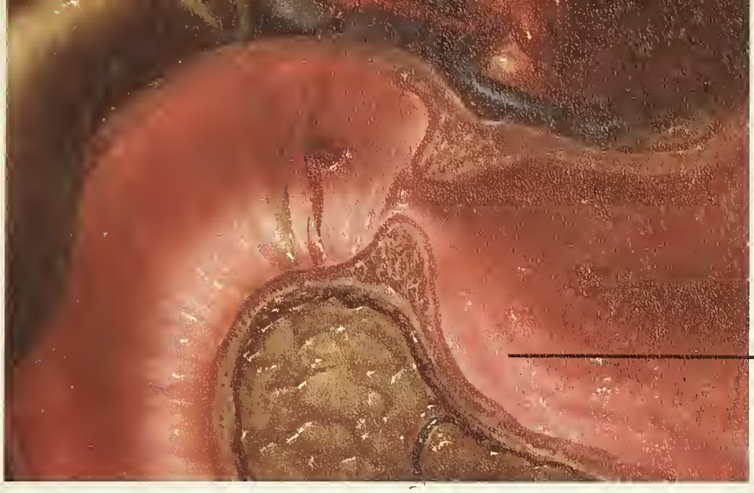
A 48 year old white male executive, suffering from hematemesis and melena for 12 hours was admitted to hospital on April 8, 1965. He gave a history of duodenal ulcer proved by x-ray studies 23 years previously. In the intervening years he suffered from typical epigastric pain occurring two hours postprandially, usually for two or three weeks each spring and fall. A hospital admission two years earlier had followed hematemesis of moderate amount.

The present admission was preceded by a recurrence of pain during a period of unusual business pressure. In addition he caught a cold one week before his entry to hospital and his already irregular eating habits were made more so by loss of taste and appetite, blocked nose and general malaise. During the final 36 hours he used aspirin to relieve his cold, taking 2 or 3 tablets with a glass of water on 6 or 7 occasions. Before retiring he drank a glass of hot toddy.

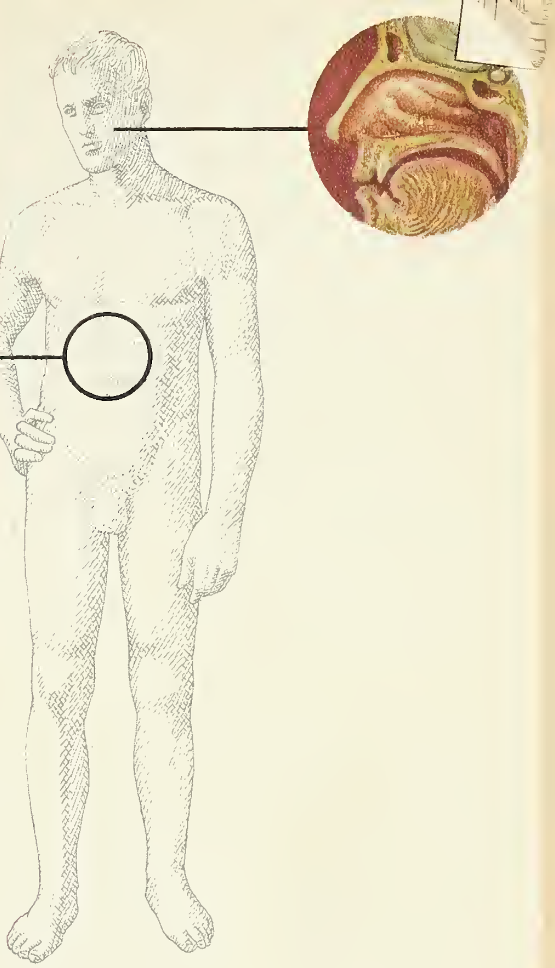
He awakened about 1 a.m. and vomited dark red blood and recently ingested food mixed with whisky. Melena followed and he was transferred to hospital. On admission he was pale, cold and sweating. Apart from epigastric tenderness and black stool on the examining finger after rectal examination, his general physical examination was not remarkable. Temperature was normal, pulse was thin and thready with a rate of 114 beats per minute, and blood



The commonly found "clover-leaf" roentgenographic abnormality of chronic duodenal ulcer due to spastic contractions and scarring.



Typical site of duodenal ulcer showing anatomical relationship to gastroduodenal artery and common bile duct.



pressure measurement was 104/60mm. of mercury. Hemoglobin estimation was 8.6 grams per cent, but white blood count, chest x-ray and urinalysis were within normal limits. No further bleeding occurred. After blood transfusions and a suitable medical regime he was dismissed two weeks later and advised to return later for consideration of surgery.

the care of the ulcer patient suffering from a viral infection of the upper respiratory tract is additionally handicapped by the local and constitutional symptoms so produced. Indifference to food often makes it difficult to "feed a cold" even in a patient without an ulcer. In the ulcer patient this becomes more than a homily, for malaise and apathy towards irksome routine produce a lack of interest in adhering to an ulcer program and result in its eventual failure if these symptoms are not relieved. The absence of curative treatment for these viral infections has spawned many a strange therapeutic offspring and some of the more generally accepted remedies contain a special risk for the ulcer patient.

To the gastric physiologist, the shot heard around the world was not fired at Concord but was discharged through the stomach of Alexis St. Martin. The worthy voyageur had a more than modest thirst and on several occasions William Beaumont observed through the resulting fistula the changes of gastritis which followed an immoderate ingestion of alcohol.[3] It is now well known that alcohol stimulates the production of gastric juice and the patient with an ulcer, even in remission, should not drink alcohol without first taking food, milk or antacid. The use of various alcoholic remedies for the common cold is to be strongly discouraged in this type of patient. Factors already present can produce an acute exacerbation of ulcer symptoms without the added stimulus of alcohol.

Headache and facial pain, sore throat and generalized aching are subjective discomforts of viral infections of the upper respiratory tract or their complications. Relief from them is usually sought in the family medicine cabinet, and of all the medications habitually stored there, salicylates are the most frequently used. Oral ingestion of salicylates has produced

I can taste, Doctor!

On Sippy diet or unrestricted regimen, food tastes better to the patient with a cold when you prescribe the oral decongestant

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Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

One tablet on arising, in midafternoon and at bedtime assures round-the-clock relief. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

(Advertisement)

substernal pyrosis and sometimes epigastric pain in susceptible individuals. Bleeding from erosions of the gastric mucosa has followed their use and has been severe :nough in some instances to cause hematemesis and nelena.[4] It has been suggested that interference vith the protective mucous layer of the stomach illows this to happen. There is no evidence that iypersecretion occurs, but the taking of aspirin has een followed by exacerbation of ulcer symptoms ind occasionally by gastrointestinal bleeding.[5] The ilcer patient with a cold should take salicylates with in antacid, or preferably other means of symptonatic relief should be found.

Caffeine has two actions on gastric secretion. One lirectly stimulates production of acid and the other otentiates the out-pouring of gastric juice as a esponse to other stimuli.[6] In high doses to animals, t has produced erosive gastritis and peptic ulceraion. Caffeine-containing beverages are discouraged or the ulcer subject and forbidden during an acute exacerbation.[7] Many cold remedies contain caffeine.

To sufferers from allergic rhinitis springtime brings ymptoms of nasal obstruction, loss of taste and mell and malaise similar to those caused by viral nfection but due instead to allergens which at that ime of year are principally tree pollens. Relief from hese symptoms can be obtained, though not wisely, y the use of steroid medication. Unfortunately, hronic sufferers from these allergies have used this ipproach with varying degrees of success. Steroid iormones increase gastric secretion and delay the iealing of experimental ulcers.[8,9] Clinically their idministration has been associated with reactivation of healed duodenal ulcers, and with bleeding and erforation which were not always preceded by ypical ulcer distress. Because of these harmful effects, their use in the ulcer patient is best avoided or other than serious medical problems and then only with adequate antacid coverage.

umming up It is immaterial by which pathways he malaise and lassitude, depression and irritability ictivate an ulcer, but it is the physician's responsiility to ensure that the medications he selects to elieve the symptoms of a cold do not further aggraate the ulcer.

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*Author's name on request.

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Phenylpropanolamine hydrochloride	12.5 mg.
Pheniramine maleate	6.25 mg.
Pyrilamine maleate	6.25 mg.

For nasal congestion regardless of cause, you can bring quick, lasting relief. Magic? Perhaps so to your little patients. To you, it's sound therapy. You may occasionally encounter these side effects: drowsiness, blurred vision, cardiac palpitations, flushing, dizziness, nervousness or gastrointestinal upsets. Precautions: the possibility of drowsiness should be considered by patients engaged in mechanical operations requiring alertness. Use with caution in patients with hypertension, heart disease, diabetes, or thyrotoxicosis.

Over 185 million doses prescribed

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Letters from the Mailbox

(More Letters, Page 501)

Many thanks to the MSMS staff and MSMS mem-ers who made our recent visit to East Lansing pos-ible.

We were all justly impressed by the physical set-ing of MSMS, but were even more impressed by the enuine, personal interest that was shown us.

It certainly was a splendid opportunity for medical tudents to voice their thoughts in a most receptive nd congenial atmosphere.

Appreciatively yours,
WILLARD STAWSKI, *President*
Michigan Medical School Class of 1966

---

ear Doctor Harris:

I read with much interest the item in the recent ssue of MICHIGAN MEDICINE about your Medi-label roject. It sounds like a most worthwhile project and ne that should conceivably be extended to all 50 tates.

Since we at Smith Kline & French feel a great sense f responsibility for public health, I would be very nuch interested in exploring the possibility of offering omething like your Medi-labels to other groups round the country. Would it, therefore, be possible or you to send me a sample of the label being used n Michigan?

Very Truly Yours,
ALAN S. WITKIN
Special Projects Administrator
Smith Kline & French Laboratories
Philadelphia, Pennsylvania

A highlight of the 115th Annual Convention in hicago will be an open house at the American Med-al Association headquarters, a "welcome" to our embers and their guests.

I personally wish to invite you to visit AMA head-uarters during your stay in Chicago. A tour of our ine-story building, including the new Institute for iomedical Research, will acquaint you with the many ctivities and services of your Association.

A special corps of tour guides will be on hand hroughout the week—on-the-hour, 9 a.m. to 4 p.m., onday, June 27 through Friday, July 1—to escort ou through the building.

All physicians' wives, medical students, exhibitors nd other Annual Convention guests are welcome.

Sincerely,
F. J. L. BLASINGAME, M.D.
Executive Vice President
American Medical Association

Enclosed is our check for $2 for one copy of "Century of Service in Medicine" which the Kent County Medical Society will present to the Grand Rapids Public Library.

We are contacting the library committees of the local hospitals to determine whether they may be interested in copies.

Sincerely yours,
Kent County Medical Society

The AMA Community Relations Department has moved from the AMA Communications Division to Field Service. Darrell Coover will continue as its director, and Mrs. Sue Boe will be Field Representative for Community Relations.

The AMA Community Relations Department has as its basic goal helping you in your efforts to increase liaison with civic, public, religious, fraternal and other groups at the local, state and national levels.

One step will be to locate the physicians and their wives who are already active in such groups. Another will be to promote dialogue between medicine and other groups in the community, state and nation. A third is to get more physicians and their wives active in such groups at all levels.

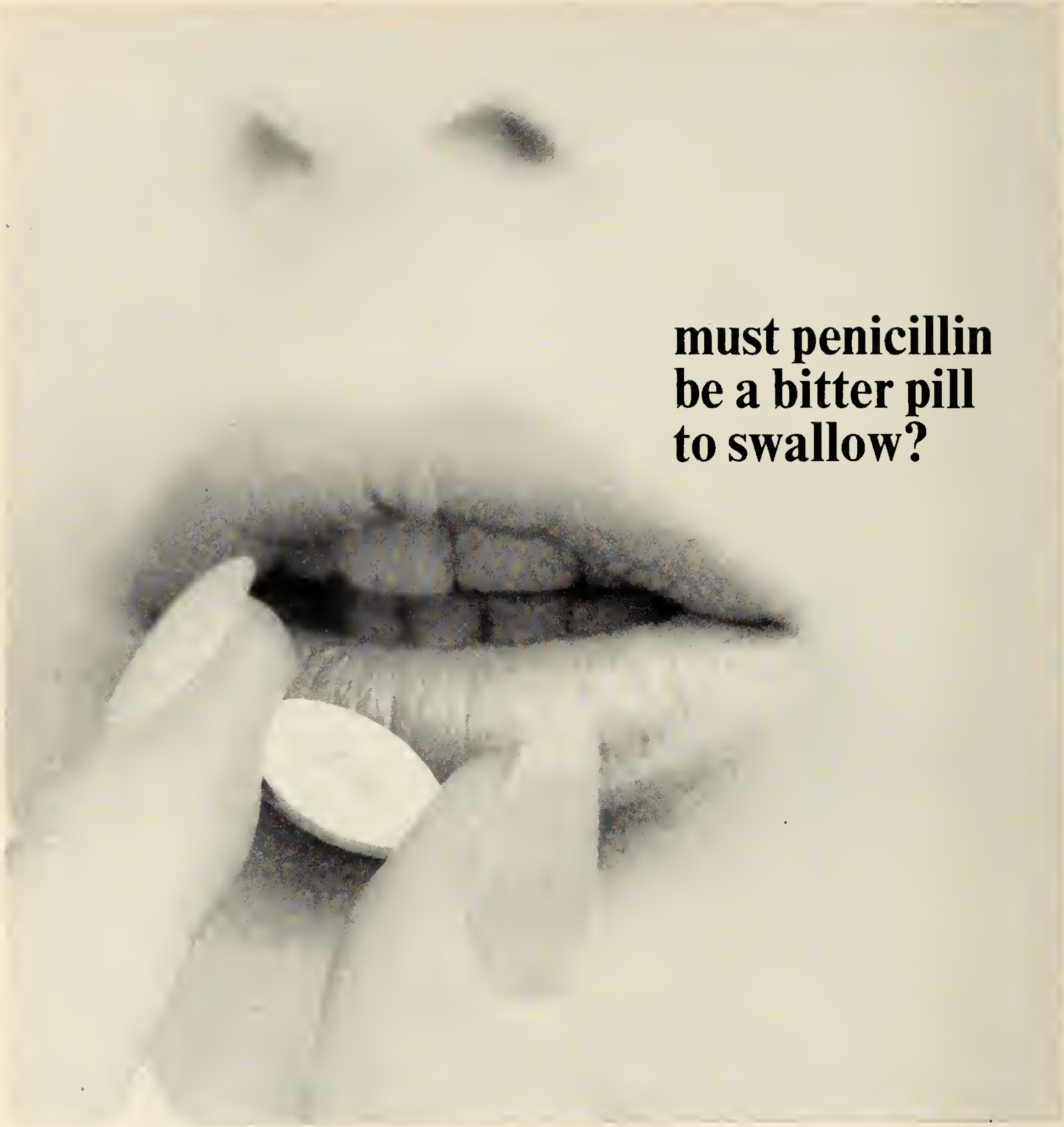
This is a recognition of the fact that group action is more effective today. The Michigan State Medical Society is proof of this. However, we need *effective participation* by physicians and their wives in these groups, and this department is looking for opportunities to help you in this task. The result should be a more understanding climate for medicine.

—AUBREY D. GATES, *Director*
AMA Division of Field Services

The MSMS Healthmobile's appearance in Bay City was acknowledged and heralded with enthusiastic acclaim. It afforded our citizenry a unique opportunity to observe, in a capsule, medicine's progress in practical terms.

It offered a medium of education and information on medical accomplishments so easily taken for granted in the everyday hustle and bustle of life's activities. It undoubtedly will stimulate at least a few children and students to medical and paramedical careers in the future, I believe.

HOWARD T. KNOBLOCH, M.D., President
Bay-Arenac-Iosco County Medical Society



Not if it is V-Cillin K.

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Indications: V-Cillin K is an antibiotic useful in the treatment of infections caused by streptococci, pneumococci, and sensitive strains of staphylococci.

Contraindications and Precautions: Although sensitivity reactions are much less common after oral than after parenteral administration, V-Cillin K should not be administered to patients with a history of allergy to penicillin. As with any antibiotic, observation for overgrowth of nonsusceptible organisms during treatment is important.

Usual Dosage Range: 125 mg. (200,000 units) three times a day to 250 mg. every four hours.

Supplied: Tablets V-Cillin K, 125 or 250 mg.; also, V-Cillin K, Pediatric, 125 mg. per 5-cc. teaspoonful, in 40, 80, and 150-cc.-size packages.

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ORIGINAL
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ARTICLE

THE TREATMENT OF ALCOHOLISM IN A GENERAL HOSPITAL

By Richard C. Bates, M.D.*
Lansing

The delegates of the American Medical Association decided in 1956 that alcoholism was a disease that should be treated in general hospitals. This action and growing community pressures have created interest in such treatment facilities in many hospitals.

Therefore it is believed a discussion will be helpful. relating our experiences and procedures at the Edward W. Sparrow Hospital in Lansing, Michigan, where there have been 1500 admissions of 1000 different individuals for the treatment of alcoholism between April 1961 and July 1965.

Preparation

Initial fears that a unit for treating alcoholics might cause resentment were groundless because adequate education of the community had been carried out by a citizens' committee. We would recommend such a move as an important first phase.

From this, phase two might be the development of an alcoholism information and counseling center supported by as many community sources as possible.

When these efforts (which may take several years) have stabilized, the opening of an in-patient treatment facility will appear as a need and will be acceptable to the community. Participation of A.A. members in all these moves is not vital, but will be valuable and easily obtained if mutual trust and communication are maintained.

Phase three, the hospital treatment center, should be inaugurated by educational programs for the medical staff, the nursing staff and general hospital personnel so that the treatment of alcoholics will be accepted as interesting and worthwhile.

Next, a program of patient instruction and therapy must be set up, and then admitting procedures and staffing are all that remain to be organized.

Physical Features of the Alcoholism Unit

At first we used general beds throughout the hospital. No unpleasant reactions resulted and all personnel had a beneficial exposure to alcoholics, finding them to be, if anything, more pleasant and attractive than many other patients.

However, we believe therapy has been far more successful since we have occupied a separate unit devoted to this purpose. Dispersion of patients means they must be rounded up several times daily for classes. Furthermore, alcoholics placed on general wards will be occupying acute-care beds which may cause criticism if physically ill patients await admission.

Other advantages of a separate unit include the following: (1) A constant interchange of therapy goes on all day when patients live together; (2) grouped patients are more available to A. A. members, ministers and "alumni" who drop in; (3) nurses on the unit develop special skills; (4) money is saved by having minimal staffing since most patients are ambulatory; (5) effective policing of the occasional uncooperative patient comes from his peers; and (6) special physical features as outlined below can be offered.

From our experience, in a community with our rate of alcoholism and on the basis of a ten-day stay, we would estimate that one bed per 20,000 persons in the immediate drawing area will be required. Males and females may be safely lodged in adjoining rooms. A lecture-dining-day room equipped with blackboard, movie screen, television set and tables is valuable. Popular special features of our unit are a refrigerator stocked with quantities of snacks and soft drinks, a coffee urn filled with decaffeinated coffee,* an automatic washing machine and ironing board, a small library of books on alcoholism and mental health, and an interview room also used by those who wish to have privacy for meditation or visitors. Intoxicated patients are admitted to a room with low beds in direct view of the nurses' desk.

Therapy—The Physical Treatment of Withdrawal

Treatment must always be dictated by the attend-

Medical Director, Sparrow Hospital Alcoholism Therapy Unit, 2909 E. Grand River Avenue, Lansing, Michigan 48912.

*Originally, regular coffee was supplied, but the need for sedation has been materially reduced since we switched to decaffeinated brands.

ing physician, but we have had good cooperation in the use of a set of "standard orders" (Table I) which permit nurses to use their greater experience in judging doses of sedatives. Physicians who wish to give specific orders for medication must be prepared to be called several times daily (or see their patients that often) since needs for sedation depend on such variables as visitors, upsetting class sessions, the speed of detoxification and the depth of dependency.

One point must be made strongly — adequate sedation must be given in the first few days, and this usually means *heavy* sedation. With other authors, we agree that tranquilizers alone do not always suffice. Barbiturates, in our experience, are safe, important to quiet management of the ward, and often lifesaving. We have not recognized any untoward effects from their use on hospitalized patients. It is important that patients go promptly to bed after receiving a "sleeper," or an occasional individual will stay up and enjoy a "jag" especially if coffee or other caffeine-containing beverages are available to counteract the hypnotic effect of barbiturates.

Delirium tremens is a most serious manifestation of withdrawal and requires expert handling. It constitutes one of the important reasons for an alcoholism unit in a general hospital. While some report a 10 per cent mortality rate and mention D.T.'s lasting five days, we have never had a fatality and seldom fail to have patients lucid and eating within 24 hours. We use neither vitamins nor steroids but depend on large doses of intravenous barbiturates to produce 12 hours of light anesthesia followed by nurses highly skilled at poking soft foods into groggy patients.

For all our patients our routine includes neither oral nor intravenous vitamins because of our strong prejudice that the proper therapy of alcoholic deficiency states is food, not shots and pills. Because of adequate sedation, restraints are not required on our ward.

While heavy sedatives are required for the first two or three days, rapid reduction of dose is then carried out and all drugs are discontinued at discharge. Almost never do we issue prescriptions or drugs for self-medication on an out-patient basis, but alumni who are having acute anxiety ("dry drunks") are encouraged to come to the floor at any hour and obtain a few tranquilizers and a visit with the nurse to tide them over.

Mental Therapy

Here, the keystone of our therapy is 21 hours of lecture and discussion weekly. Few patients can absorb more than three one-hour sessions in one day, so longer or more frequent classes often defeat their purpose. We use volunteer teachers including physicians in practice, interns and residents, clergymen, social workers from the community and hospital social service department, nurses and A.A. members (Figure 1). Some of our "faculty" lecture as often as twice weekly, others as seldom as twice yearly. We do not require that a teacher have any formal training in alcoholism nor do we direct his lesson content. As a result, some of our lecturers have come away with more knowledge than they brought, and in fact, we have sometimes selected them with this result as a goal. Only four teachings are forbidden: that alcoholism is hopeless, that alcoholics are worthless, that A.A. is useless or that partial sobriety and controlled drinking are attainable for alcoholics.

To ensure that our subjects will know where to find a most important source of help after discharge, we devote several evening class sessions to A.A. or Al-Anon meetings on the ward. In addition, A.A. members pick up patients several evenings a week and take them out to meetings at the local "Alano club."

Visitors, relatives, students writing papers, and curiosity seekers are invited to visit the ward and sit in on classes at any time, no questions asked.

Admission Policies

Our policy is to place as few barriers as possible between the alcoholic and his bed. As a means of screening those who seek comfort rather than treatment, we do try to exact a promise of a ten-day stay before admission. Thanks to a beneficient and understanding administration, this is the only obstacle between intoxicated patients and the unit. Interviews in admitting and credit departments expose an intoxicated person to public gaze, result in inaccurate information and may cause flight of one who has taken years to develop the desperation and/or courage to come. Our motto is, "Get his pants off first and *then* ask questions." If it appears that

ABSTRACT—Alcoholism can be successfully treated in any general hospital, particularly if interested physicians can spark an educational program for patients leading to prolonged therapy after discharge. Such a program, in operation at Sparrow Hospital in Lansing for four years, is described here. It includes several unusual features in patient care such as unlimited access to food, 21 hours of instruction a week and an open admission policy.

e should *not* have been admitted, little expense is ncurred if he is discharged as soon as the error is liscovered. We believe no hospital can safely send n intoxicated person away. Alcoholics are admitted y the floor nurse without permission from a physiian. If they have no physician, one is appointed rom a panel. Those who request admission while ober are screened either in the emergency room or y the nurse, since out-patient therapy may suffice or that alcoholic who can stay dry five days in a row.

We reject only those who have shown no interest n learning during previous admissions, those very are individuals who have brought liquor on the ward *after* admission (a fair number bring bottles r tranquilizers when they arrive and this contraband hould be removed while they are in their first sleep) nd those who we feel, from our previous experience with them, will benefit more by being cast onto their wn resources at this particular point in therapy. 'Unto everything there is a time" and premature escue to an occasional alcoholic may postpone his eaching a lasting "bottom." When in doubt it is lways safer to admit and speedily discharge than ot to admit at all. Rejection of a patient should lways be under direct orders of a physician. In ractice any individual rejected from our unit may e admitted by the simple expedient of finding anther doctor, but we do maintain in the nursing tation a file card on every patient containing brief nformation such as "uncooperative," "didn't attend lasses," "signed out against advice," "not a good andidate for therapy," and the nurse may pass these omments on to new physicians. These cards also ontain such valuable information as the dates of previous admissions, collateral addictions to drugs nd narcotics, previous occurrence of D.T.'s or withdrawal convulsions, and any other facts that should be available in the first few hours of stay.

Finances

In approved hospitals, most insurance policies pay full fees under the provision of benefits for treatment of mental illness. We have had a few small companies initially refuse to consider alcoholism as a legitimate mental illness, but these matters have been adjusted subsequently.

Naturally, a high incidence of indigent patients is encountered. Enlightened welfare departments recognize that one alcoholic transferred from relief to tax rolls saves enough to pay for the hospitalization of many. In communities where uneducable departments operate, charging full fees for care of these limited-care patients may permit a profit that will enable subsidization of the best prospects among the indigents. The others are "dried out" for three days and placed on day-care therapy. We have demonstrated that we can operate our unit to profit, break even or lose, depending on two factors: the handling of indigents and occupancy rates. The closest coordination is maintained between the business office and the unit staff so that unnecessary losses do not occur.

TABLE I
Routine Orders for the Treatment of Alcoholism

1. Up ad lib
2. General diet
3. Routine blood and urine examinations
4. VDRL laboratory test
5. Routine admission chest x-ray
6. Tuberculin Tine Test if under 30 years old

   } if not done in preceding six (6) months

7. Aspirin 0.65 gm. (0) q. 4 h. p.r.n. pain x 10 days
8. Antacids, 30 cc orally q. 2 h. p.r.n. stomach distress x 10 days.
9. Promazine (Sparine)
   a. Up to 50 mg. (0) p. 2 h. p.r.n. agitation and tremor x 3 days. After 3 days reduce to 25 mg. TID x 7 days if pulse is below 100 and withdrawal tremors are subsiding.
   b. 50 mg. (deep I.M.) q. 2 h. p.r.n. if agitation not controlled by oral medication x 3 days.
10. Pentobarbital (Nembutal)
    a. 0.2 gm. (0) or (I.M. if necessary) at H.S. Repeat once if necessary, daily x 3 days.
    b. 0.1 gm. (0) (I.M. if necessary) at H.S. Repeat once if necessary, daily after 3 days x 7 days.

Length of Stay

For the first admission we find ten days the optimum for those who are physically healthy. Assuming that patients will be occupied with routine laboratory tests and may be too sick to absorb much the first day, nine days are left for instruction. Provided out-patient therapy is available, longer stays may give diminishing returns because the novice often becomes unduly optimistic that achieving sobriety involves nothing more than avoidance of drinking. At this point he will stop learning; he is ready to go out where the best teacher awaits.

On subsequent admissions, five to seven days may suffice since some previous training has been given. Obviously, flexibility is required here.

Leaves are freely granted to take care of business affairs, appear in court, have dinner with the family or just walk around the block, as long as they do not cause absence from classes. As indicated above, indigent patients are hospitalized only through the acute withdrawal (one to three days) and then transferred to day care.

Day Care

For those who do not require or who cannot afford in-patient therapy, arrangements are made to live on the ward during the day and attend all classes, paying only for meals. Medicines are provided through donations from former patients. Patients for day care must be selected and watched carefully, since they have greater freedom to consume alcohol and drugs while under treatment. Sometimes it is useful to warn patients at the start of day care that they may be required to submit to a blood test for drugs or alcohol, or to take a disulfiram (antabuse) tablet at any time. Others may be required to take a crushed* disulfiram tablet at the start of each day.

Personnel

The unit is headed by a voluntary medical director working with a paid full-time program coordinator. The coordinator arranges all the classes, coordinates all therapy in both the in-patient and day care, involves and counsels the relatives of patients, does an intake history on each admission and works with students interested in alcoholism.

In our 13-bed unit (which occasionally expands to 18, since we have never turned a patient away because our beds were full) one R.N. and two aides are sufficient for the day shift, with a practical nurse for each of the other shifts. During these other periods, the practical nurses call R.N.'s from adjoining wards when necessary and the nursing supervisor circulates frequently. Patients are encouraged to make beds and wait on each other as part of their therapy.

The nurse is perhaps the most vital member of the team and it would be well if she were to have training in psychiatric nursing and/or the Rutgers School of Alcoholism Studies.

Although we managed without them at first, we now enjoy the assistance of medical social workers.

An occupational therapist spends an hour a day helping with simple nonfrustrating craft projects that can be finished in a short period and yet provide self-satisfaction.

Because alcoholics are immature, personnel should be selected who appear to have the qualities of good parents: emotional stability coupled with firmness and compassion. Workers on the unit must support each other or else a clever alcoholic, like an adolescent with his parents, may divide and conquer them.

Philosophy of Therapy

We do not attempt to keep patients against their will if they are in full possession of their faculties. There are no locked doors or window bars, and clothes are left in the room. We try to get the usual "release" form from those who depart prematurely but do not threaten that they cannot return. This freedom to come and go is comforting to those who fear being locked up, as in a psychiatric unit. Conversely, we have often invited critical, demanding, threatening or belligerent individuals to leave and are usually rewarded with better behavior. Our attitude toward most patients is that they are students. Attendance at our course of instruction is a privilege and those who cut classes may be flunked out.

We attempt to give all the help we can toward establishing a new life and personality in the short time we have. We do not expect to cure these people, but rather to point them in that direction. No one has determined the best way to treat alcoholism, so we offer a veritable smorgasbord of therapy, recognizing that one may get help from a clergyman, another from a social worker, and many from A.A. Even our floor sweeps have occasionally rendered therapy. Although it is sometimes difficult, we try to keep each school of therapy from derogating the others.

Goals

First, we appraise the physical state, looking principally for injuries, brain and liver disease. Second, we look for other medical diseases because alcoholics are hypochondrial and because many of them have not had a physical exam in years. Happily, physical complications of alcoholism are relatively rare because most of our patients are in the early and middle phases of their illness.

We are ever alert for other addictions (because they require more careful withdrawal therapy), for convulsions (rum fits) and for D.T.'s. Psychotics are too ill for our therapy and they disturb the others, so they must be swiftly sorted out and transferred. Senile or deteriorated individuals cannot be taught and are transferred to custodial care as soon as their physical derangements are settled.

Next we diagnose the state of the patient's maturity and attitudes toward his disease and help him to the next grade in his education. In order, he must be convinced (1) that he is an alcoholic, (2) that he can never drink again and (3) that he probably will need continuing and long-term help to accomplish a happy sobriety. We show him where such can be found.

If possible, we also interview his immediate circle of relatives and his employer and try to point the path toward the best final result for all concerned. Resort to other community agencies for employment, legal aid, shelter and clothing, marriage counseling, child guidance, debt management and welfare aid is

The Author

Richard C. Bates, M.D.

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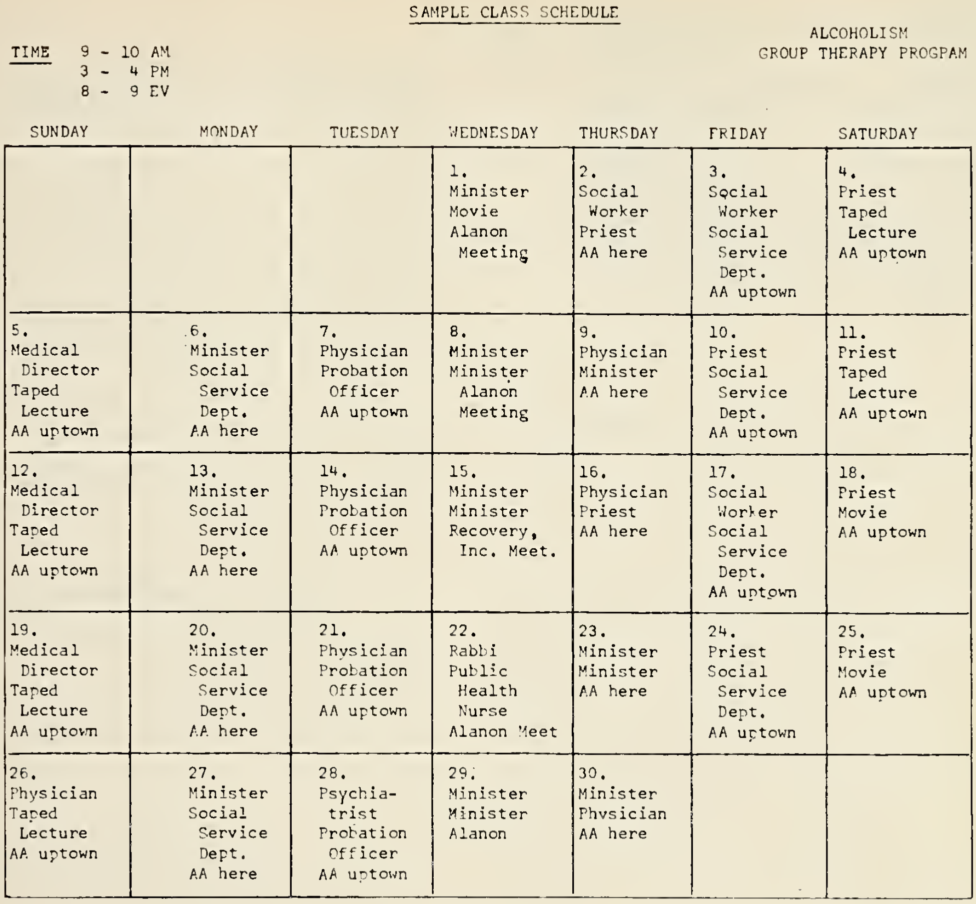
*When administered by others, disulfiram should always be given crushed in a swallow of water and washed down with more fluids to ensure that the patient does not hold the tablet in his cheek and discard it later.



SAMPLE CLASS SCHEDULE

ALCOHOLISM
GROUP THERAPY PROGRAM

TIME 9 - 10 AM
3 - 4 PM
8 - 9 EV

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
			1. Minister Movie Alanon Meeting	2. Social Worker Priest AA here	3. Social Worker Social Service Dept. AA uptown	4. Priest Taped Lecture AA uptown
5. Medical Director Taped Lecture AA uptown	6. Minister Social Service Dept. AA here	7. Physician Probation Officer AA uptown	8. Minister Minister Alanon Meeting	9. Physician Minister AA here	10. Priest Social Service Dept. AA uptown	11. Priest Taped Lecture AA uptown
12. Medical Director Taped Lecture AA uptown	13. Minister Social Service Dept. AA here	14. Physician Probation Officer AA uptown	15. Minister Minister Recovery, Inc. Meet.	16. Physician Priest AA here	17. Social Worker Social Service Dept. AA uptown	18. Priest Movie AA uptown
19. Medical Director Taped Lecture AA uptown	20. Minister Social Service Dept. AA here	21. Physician Probation Officer AA uptown	22. Rabbi Public Health Nurse Alanon Meet	23. Minister Minister AA here	24. Priest Social Service Dept. AA uptown	25. Priest Movie AA uptown
26. Physician Taped Lecture AA uptown	27. Minister Social Service Dept. AA here	28. Psychiatrist Probation Officer AA uptown	29. Minister Minister Alanon	30. Minister Physician AA here		

Figure 1.

intimate since representatives of these agencies often recruit our patients and teach our classes.

Results

There are available no reliable statistics on the success rate of our unit since we have only been in operation four years. In 1500 admissions in a four-year period we have had only 11 deaths — four from liver failure, two from lung diseases, two from brain laceration, one from aortic aneurysm, one from salicylate poisoning and one undiagnosed. A fourth of our patients come to us from outside our usual drawing area — some from a hundred miles away. Some days there are 60 people in the day-room listening to lectures. If these facts do not certify our success, they at least attest to the need.

Summary

For four years we have maintained a successful unit in a general hospital for treatment of alcoholism. We find that the essential features of such units include heavy sedation of new patients when needed, enlightened attitudes in the community and in all levels of hospital personnel, skilled nurses and an intensive educational program for therapy.

Not essential, but valuable, are a separate ward for this activity, participation by representatives of Alcoholics Anonymous, medical social service workers, psychologists and occupational therapists, volunteer lecturers and counselors from the community. A day-care program helps reduce costs.

Unusual and successful features of our facility include direct admissions to the floor, freedom to leave, unlimited access to snack foods, and avoidance of vitamins and steroids in therapy.

"Medicine in Our Changing World"
Theme for MSMS Annual Session, Grand Rapids,
September 27-28-29-30

ORIGINAL
SCIENTIFIC
ARTICLE

REPAIR OF BILE DUCT STRICTURES

By Charles G. Child, III, M.D.*
S. Martin Lindenauer, M.D.**
Both of Ann Arbor

Introduction

Operative injury to the extrahepatic biliary tree accounts for virtually all benign bile duct strictures.[3] The exact incidence is hard to estimate since most clinics that accumulate experience in the repair of bile duct strictures are referral centers.

These patients continue to appear despite general progress in the improvement of surgical skills. As emphasized by Cattell[3] and others,[4,5] operative injury to the bile ducts is often associated with inadequate exposure and assistance and suboptimal anesthesia. The presence of acute inflammatory disease, bleeding and congenital anomalies are frequently concomitant factors. It is likely that there will always be a number of such injuries. The purpose of this paper is to examine the recent experience in the management of this problem at the University of Michigan Medical Center.

University of Michigan Experience

During the period 1959 to 1964, fifty-two patients have been treated for bile duct stricture. As can be seen from Table I multiple operations were required to achieve correction of this injury, emphasizing the difficulty of repair.

The etiology of these strictures is outlined in Table II. Operative injury is responsible for 86.4 per cent of bile duct strictures with the majority occurring during the course of cholecystectomy. Congenital stricture was not observed in this series.

The choice of a method of repair is governed by the amount of normal extrahepatic biliary tissue present. In most instances an end-to-end repair with simple excision of the stricture is not possible. A biliary-enteric anastomosis is required in the majority of cases and at the University of Michigan, a roux-en-Y hepatico-jejunostomy is favored.

Fifty-six per cent of the repairs in this series were accomplished by means of a roux-en-Y hepatico-jejunostomy which was usually fashioned in an end-to-side manner with the jejunal limb placed in a retrocolic position (Table III). The bile duct stricture was amenable to Heineke-Mikulicz type plastic repair in 25 per cent of the cases. The single patient who underwent tube drainage only, had severe biliary cirrhosis and required a portacaval shunt to control variceal hemorrhage. She remains alive, but with

TABLE I
University of Michigan Experience 1959-1964

Total number of patients	= 52
Total number of operations	= 129
A. Performed elsewhere	= 38
B. Performed at the University of Michigan	= 81
Average number of operations per patient	= 2.5

TABLE II
Etiology of 52 Bile Duct Strictures
University of Michigan 1959-1964

I. Operative injury during the course of:	
1. Cholecystectomy	= 42 (80.7%)
2. Excision of duodenal diverticulum	= 2 (3.8%)
3. Gastrectomy	= 1 (1.9%)
II. Stricture secondary to biliary enteric anastomosis during the course of:	
1. Pancreaticoduodenectomy	= 4 (7.7%)
2. Choledochal cyst-enterostomy	= 2 (3.8%)
III. Non-operative Trauma	
1. Automobile accident	= 1 (1.9%)

TABLE III
Method of Repair in 52 Bile Duct Strictures
University of Michigan 1959-1964

Hepatico-jejunostomy (roux-en-Y)	= 29
Heineke-Mikulicz Plastic Repair	= 13
Dilatation Only	= 4
Choledochoduodenostomy	= 2
Tube Drainage Only	= 1
Operative Deaths	= 3

TABLE IV
Results of Repair of Bile Duct Strictures in 52 Patients
University of Michigan 1959-1964

Excellent (no cholangitis, no biliary cirrhosis)	= 73%	(38)
Good (no cholangitis, mild biliary cirrhosis)	= 10%	(5)
Poor (recurrent cholangitis)	= 4%	(2)
Deaths, all	= 13%	(7)
Operative deaths	= 5.7%	(3)
Deaths, related to biliary tract disease	= 5.7%	(3)
Unrelated deaths	= 1.6%	(1)

From the Department of Surgery, University of Michigan, Ann Arbor, Michigan

**Professor and Chairman, Department of Surgery, University of Michigan*

***Instructor, Department of Surgery, University of Michigan* er shunt thrombosed and severly compromised liver unction preventing further attempts at repair.

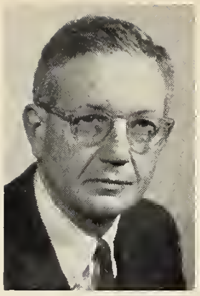
Results are tabulated in Table IV and were good r excellent in 83 per cent. The total mortality om biliary stricture, including the operative deaths, as 11.4 per cent. Postoperative liver function studies ere obtained in all patients and were persistently bnormal in 42 per cent. A pathologic diagnosis of iliary cirrhosis was made in 25 per cent of the total roup. Three patients are living with symptomatic epatic insufficiency. The duration of followup was to 105 months. The average length of followup as 20.1 months.

iscussion

Aside from the occasional instance of non-operaive trauma, and the rare congenital stricture, virually all bile duct strictures are the result of operaive injury. Hence, emphasis on the prevention of njury would seem to be the logical approach to the roblem rather than further refinements in, or comarisons of, different methods of repair. Nevertheess, it is realistic to accept the fact that surgeons will ontinue to be challenged by the problem of repair f bile duct strictures.

Various techniques of repair have been advocated. attell[3] emphasized the importance of attempts at epair whenever possible. He favored an end-to-end epair and pointed out additional techniques to help chieve this, but if sufficient ductal tissue was not resent he preferred a loop hepatico-jejunostomy.[1] Valters[5] advises a hepatico-duodenostomy, whereas ole[4] suggests a roux-en-Y hepatico-jejunostomy. All uthors[1,3,4,5] emphasize the need for prolonged tube rainage (6 to 12 months). Cattell, Braasch,[2] and Varren[6] advocate an indwelling Y-tube in a twotage procedure. The rationale for long-term intubaion is to allow fibrous tissue to mature and thereby nhance long-term patency rates. The use of an inwelling Y-tube is advocated if the stricture isloated at or near the origin of the common hepatic uct, if the tissues are inflammed, or if there have een repeated failures in attempts at repair.

At the University of Michigan, tube drainage for rolonged periods is not utilized. A fenestrated traight catheter is used to splint the anastomosis n the early postoperative period. It is positioned cross the anastomosis so that fenestrations are presnt on each side of the suture line. The catheter xits through the jejunal limb and is removed in wo to three weeks. Emphasis is placed upon a large nastomosis with careful mucosal apposition to discourage recurrent stricture formation rather than upon long-term intubation.



C. G. Child, III
M.D.

S. M. Lindenauer,
M.D.

Heineke-Mikulicz type plastic repair is advocated for suitable localized strictures.

In the presence of a severe stricture, with little recognizable ductal tissue present, and markedly impaired liver function, external tube drainage is often utilized as a primary procedure. This allows the acute inflammatory response in the region of the porta-hepatis to resolve. There is often a dramatic decrease in the size of the liver which uncovers a further length of proximal hepatic duct. In addition, there is improvement in liver function and in the general metabolic and nutritional status of the patient. After a suitable interval of 4 to 12 weeks, definitive repair is accomplished by means of roux-en-Y hepatico-jejunostomy. The staging of difficult strictures in this manner has improved the operative mortality and allowed definitive repair to be accomplished more often.

A stricture amenable to excision and end-to-end repair has rarely been seen in our experience. The stricture is either small enough to allow a plastic type procedure or it is so extensive that an enteric anastomosis is required. The roux-en-Y method is favored since it is felt that this provides the best protection against reflux of enteric contents and subsequent ascending cholangitis. It has been suggested that diversion of the alkaline bile to the roux-en-Y limb of jejunum may predispose to duodenal ulcer formation. However, this complication has not been seen in this series.

Utilization of these techniques has provided results that compare quite favorably with other series.[1,5,6] The followup period of observation, however, is short and there probably will be patients who will require further revision. It has been well shown[2,5,6] that in the repair of bile duct strictures,

ABSTRACT—The authors reviewed a series of 52 patients who required treatment for bile duct stricture. Multiple operative procedures ave been used in an attempt to correct the abnormality. The technique sed by the authors is reported in detail. It was successful in 83 per cent.

long periods of observation are necessary to assess ultimate results.

Summary

At the University of Michigan Medical Center, 52 patients have been treated for bile duct stricture during the period 1959 to 1964. These patients have been followed an average of 20 months, with good or excellent results in 83 per cent. The operative mortality was 5.7 per cent. Overall mortality related to biliary tract disease was 11.4 per cent. Techniques and principles of repair are briefly outlined.

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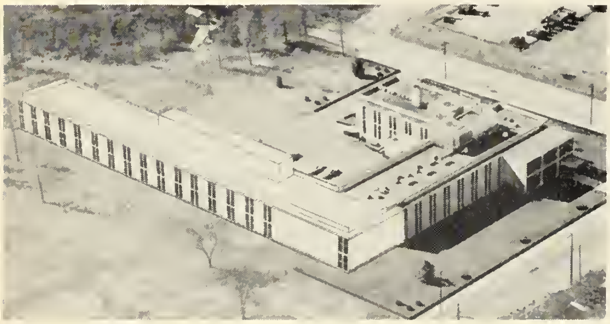

A. H. Robins, pharmaceutical manufacturer, will double the size of its research center at Richmond, Va. E. Claiborne Robins, president, explains the $2 million project is being undertaken to keep pace with the company's growing research and development program. An east wing will give the research staff of 80 scientists more working room and provide for future expansion of its activities in chemical research, pharmacology, biochemistry, microbiology and pharmacy research. The addition will contain approximately 54,000 square feet of space.

The new facilities are expected to be ready for use in July 1967.

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ARTICLE

BLEEDING GASTRIC CARCINOID: A RARE CONDITION

By Paul J. Connolly, M.D., F.A.C.S.
William S. Carpenter, M.D., F.A.C.S.
Robert D. Allaben, M.D., F.A.C.S.

All of Detroit

Carcinoid tumors, known also as argentaffin and enterochromaffin tumors because of their characteristic staining qualities, are neoplasms composed of clusters, sheets or strands of ovoid or round cells which contain ovoid vesicular nuclei. The neoplasms are rarely more than 3 cm in diameter, and may be spheroid, sessile, or polypoid.

When fixed in formalin with a slightly acid pH, the cytoplasmic argyrophile granules are demonstrable by means of impregnation with silver. The cells are believed to derive from Kulchitsky cells in the basigranular layer of the crypts of Lieberkuhn in the intestinal tract or from their precursors, the presenterochrome cells.

Nonencapsulated but circumscribed, carcinoids tend to expand into the muscularis and may involve the lymphatic channels and nerve sheaths. They have been identified throughout the GI tract, generally below the diaphragm, in the mucosa of the small intestine, Meckel's diverticula, and appendix; less frequently in the colon and rectum; and rarely in the gastric mucosa.[1,2,3]

Carcinoids comprise 20 to 25 per cent of all tumors in the small bowel and are multiple in 30 per cent of these. To point out the benign nature and because he did not believe these tumors metastasized, Oberndorfer gave them the name "carcinoid."[4] While these tumors rarely metastasize from their most common site, the appendix, reported metastasis from other primary sites vary from 25 to 75 per cent.

The Carcinoid Syndrome

The carcinoid syndrome is usually found only in patients with metastasis to the liver and lymph nodes. The syndrome is due to the elaboration in large amounts of 5-hydroxytryptamine (serotonin), a powerful hypertensor.

This substance causes a variety of symptoms, chief of which is flushing of the skin of the head and neck, although palpitation, weakness, nausea, diarrhea, dyspnea, syncope, and paresthesia are also described. Pain may or may not be present, depending on the area involved.

When serotonin levels have been elevated for a long time, the valves of the right side of the heart become fibrosed, producing pulmonary and tricuspid stenosis. Indeed, death caused by carcinosis is usually due to cardiac failure associated with these lesions.[5] Other associated conditions are peptic ulcer, asthma, nonspecific arthritis, and mental disorders.

By enzymatic action 5-hydroxytryptamine is broken down in the body to 5-hydroxyindolacetic acid, (HIAA), which is excreted in the urine. The presence of over 50 mg of 5-HIAA in a 24-hour urine sample is diagnostic of the carcinoid syndrome.

Gastric Carcinoid

Of 2,579 cases of carcinoid analyzed from the literature by Sanders and Axtel,[5] only 86 cases were located in the stomach. Unless the carcinoid syndrome is present, these tumors cannot be distinguished from other gastric lesions such as ulcer, carcinoma, or benign tumors. In the stomach, of the 86 cases reported, 15 had metastasized, of which five had the carcinoid syndrome. The prognosis in gastric carcinoid is relatively good, only a few patients having been reported as dying of the disease.

In a review of 79 cases, Christodoulopoulos[6] found the symptoms of gastric carcinoid to be nonspecific and as follows: epigastric pain, melena, hematemesis, weight loss, anemia, epigastric burning, nausea, and vomiting. The x-ray findings usually suggest a gastric

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polyp but may resemble carcinoma, ulcer, or benign tumor.

Case Report

The patient was a 27-year-old white woman who was six months pregnant. Two months before admission to Harper Hospital she had what was considered to be a viral infection. This was characterized by malaise, weakness, loose stools, and questionable melena. After this episode, she was asymptomatic until three days before admission when she noted black and tarry stools. The following day she felt drowsy and weak. On the day of admission to the hospital, she developed right lower quadrant pain and vomited blackish coffee ground-like material.

Admitting blood pressure was 120/70 mm Hg, pulse 120/min. with a respiratory rate of 12/min. The red blood cell count was 1,470,000, and the hemoglobin was approximately 2 gm/100 ml. The patient was treated by transfusions and put on an ulcer regime. Hematologic studies showed no disorder other than the blood loss anemia. An upper gastrointestinal x-ray study was done but was modified because of the bleeding and the pregnancy; the study was negative. The patient continued to have tarry stools and required transfusions daily. In the 16 days following her admission, she was given 21 units of blood. At this time she was taken to the operating room for a laparotomy. The positive findings consisted of a uterus of seven months' gestation and a tumor of the pylorus. The tumor was on the posterior wall and to expose it, an anterior gastrotomy was made. A bleeding ulcer, 18 mm in diameter, was seen in the mucosa over the tumor. The tumor did not separate from the stomach wall and therefore the entire stomach wall was excised in this area. A Heineke-Mikulicz pyloroplasty was performed. The patient did well postoperatively and was discharged on the 11th postoperative day. When she was last heard from, seven years postoperatively, she was asymptomatic.

Pathologic Findings

The tumor was firm and elastic and measured 3 x 2.5 x 1.5 cm. One surface was covered by mucosa with a shallow ulcer filled with clotted blood. The cut surface was whitish-yellow at the periphery with a soft gray-brown central area. Microscopically the sections demonstrated small uniform epithelial cells originating at the base of a mucosal ulcer and extending into the muscularis propria. (Figure 1) The cells were arranged in nests surrounded by a vascular supporting stroma. The cytoplasm was clear and cell borders were well defined. No mitoses were seen. The diagnosis was ulcerated gastric carcinoid.

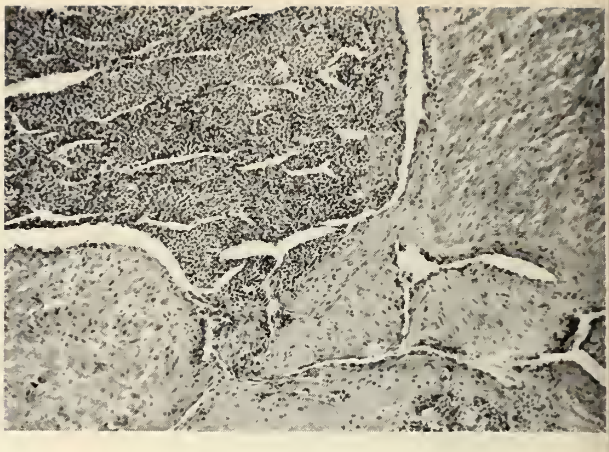

Fig. 1. Carcinoid invading muscle of gastric wall. H & E x 133.

Summary

Carcinoid of the stomach is a comparatively rare condition with a relatively favorable prognosis. Preoperative diagnosis is difficult unless the carcinoid syndrome is present. There are no symptoms characteristic of the disease, but epigastric pain and melena are the two most frequent symptoms. A case is reported of a 27-year-old pregnant woman who bled from an ulcerated gastric carcinoid. This was controlled by local excision and the patient is well seven years later.

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ABSTRACT—Carcinoid is an unusual gastric lesion with a relatively good prognosis. Epigastric pain and melena are the two most frequent symptoms. A case report is made of a pregnant woman with a bleeding ulcerated gastric carcinoid. This was controlled by local excision, and the patient is well seven years later.

COMPLETE RUPTURE OF THE TERM GRAVID UTERUS WITH A DELAY BEFORE HYSTERECTOMY

—TWO CASE REPORTS

By Theodore W. Kilar, M.D.
And David C. Gustafson, M.D.
Both of Detroit

Rupture of the term gravid uterus is a grave accident of pregnancy accompanied by a high maternal mortality.

Josey, in a combined review of 12 series, finds a maternal mortality of 36 per cent. All authors are of the opinion that a delay in diagnosis and treatment is the most significant factor favoring an increase in this percentage. Beacham and Beacham conclude, "There is a definite correlation between mortality and the time interval from rupture to laparotomy." Garnet, in his report of 21 ruptures, gives a maternal mortality of 22 per cent if treatment is instituted less than two hours after rupture. However, if treatment is delayed for more than two hours, his figure becomes 83 per cent.

Despite this need for immediate treatment of the ruptured gravid uterus, there are sporadic case reports in the literature of long delays in treatment and, in fact, complete absence of treatment with survival of the mother. There have been 21 complete ruptures of the pregnant uterus at Woman's Hospital since 1931. Of these, two are especially interesting because of the long delay before hysterectomy, despite complete ruptures of the term gravid uterus.

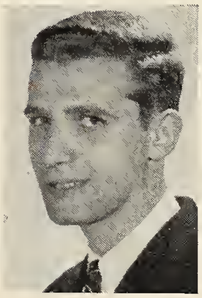
CASE 1

Mrs. B. J. W. (E-104574), a 31-year-old, gravida 5, para 3, abortus 1, Negro female, was transferred to Woman's Hospital on December 26, 1963 at 6:00 P.M. from another hospital. Her last menstrual period was in February. In 1950, 1952, and 1960, she had uneventful vaginal deliveries with infants weighing from five to seven pounds. In 1961 she had an abortion followed by a dilatation and curetage. Prior to hospitalization, her present pregnancy was uneventful.

The patient had entered the other hospital five days previously on December 21, 1963, with regular abdominal pains that she thought were labor contractions. Her admitting laboratory studies showed a trace of albumin in the urine, a hemoglobin of 10.55 grams, hematocrit of 32.0 per cent, and white blood count of 19,000.

The patient's contractions gradually ceased, and on December 23, 1963, she had some vaginal bleeding during a pelvic examination. However, subsequent vaginal examinations did not cause further bleeding. After this episode the patient had no more contractions and was observed until her transfer to Woman's Hospital. She remained afebrile and at no time was she noted to be in shock. Her blood pressure varied from 107 to 120 systolic. Oxytocics were not used.

When she was admitted to Woman's Hospital her blood pressure was 120/70, her pulse was 120, and her temperature was 98.6 degrees Fahrenheit. She was comfortable, ambulatory, and in no acute distress. Abdominal examination revealed what was thought to be a 36-week-sized uterus and the head was palpable in the right lower quadrant. Estimated fetal weight was four pounds. The upper abdomen was distended, but it was not tender and no rebound was noted. Pelvic examination revealed a cervix that admitted a finger and was about 80



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per cent effaced. The head was floating and was displaced to the right by a hand that was presenting before it. The membranes were thought to be intact.

The admitting hemoglobin was 5.2 grams. Transfusions were begun. A roentgenogram of the abdomen showed a dead fetus with a compound presentation of head and hand in the pelvis. The patient spent a restful night although the uterus was described as "hard and not relaxing" by a second examiner. However, when seen in the morning by the admitting physician, the patient looked much worse than she did the previous evening. Her temperature was 101.4 degrees Fahrenheit. Her abdomen was greatly distended and exhibited generalized tenderness but no rebound. Occasional bowel sounds were heard. The uterus was difficult to palpate but seemed tense. Despite her generally poorer condition, the patient requested solid food and wanted to sign herself out of the hospital. Her blood pressure remained stable.

At this time it was evident that definite therapy would have to be started immediately. While an additional two units of blood were being given, a repeat abdominal roentgenogram was taken and was essentially unchanged from the night before. A vaginal attempt to rupture the membranes was unsuccessful. The patient was then taken to the operating room.

At laparotomy about 1500 cc. of old clotted blood was found in the abdomen. In addition, there were multiple fibrin adhesions between loops of bowel. The infant and placenta were free with the placenta lying beneath the liver. The uterus was in front of the fetus and was well contracted to about the size of a 14-week pregnancy. The head of the infant was wedged into the pelvis. The infant weighed 5 pounds 8 ounces, and exhibited early maceration.

The uterus was found to have a complete rupture on its posterior surface extending from about 1 cm. of the external os upward through the entire lower uterine segment into the upper segment. The rupture measured 12 cm. in length (See Figure 1). It curved from the midline posteriorly slightly to the right, but both uterine arteries were spared.

A total abdominal hysterectomy was performed. The subsequent course of the patient was characterized by a mild temperature elevation for three days, but she then became afebrile and was discharged on the eighth postoperative day.

COMMENT

The pathologist noted organization about the entire circumference of the rupture. He felt that he could date these changes as being of about four to five days' duration. It is believed that this uterus probably ruptured on December 23, 1963, when the patient experienced some vaginal bleeding. Therefore, this represents a case of complete uterine rupture with extrusion of infant and placenta into the abdominal cavity and with a delay before hysterectomy of about four days.

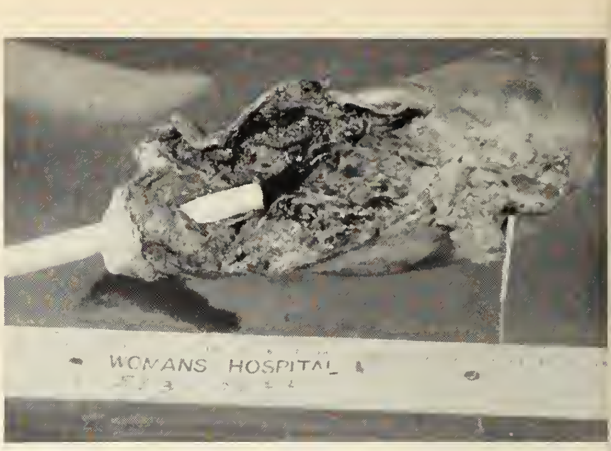

Fig. 1. Uterus removed from Case 1 demonstrating complete rupture.

CASE 2

Mrs. B. P. (E-69340), a 26-year-old gravida 7, para 6, white female with an estimated date of confinement of February 27, 1961, was admitted to Woman's Hospital on April 27, 1961. Fetal movements had been absent for about one month. Mild, irregular contractions had been present for about one week prior to admission. Examination revealed absent fetal heart tones and a soft cervix that was about 2 to 3 cms. dilated. The head was presenting and was about minus 2 station.

Past history revealed 6 full-term pregnancies with babies weighing five to seven pounds. Her last pregnancy was in 1957 and was followed by a postpartum hemorrhage and by a cervical laceration that was repaired vaginally.

The patient's membranes were surgically ruptured and intravenous Pitocin was begun. She had an easy labor and one hour and ten minutes after the Pitocin was started she spontaneously delivered a macerated 7 pounds 4 ounce female. Her blood pressure prior to delivery was 120/70, but immediately postpartum it dropped to 70/40. The placenta followed four minutes later and the blood pressure slowly rose to stabilize at 100/60.

On the first postpartum day the patient complained of abdominal pain, and her abdomen was noted to be distended. Two days later she complained of an irritating pain in her right shoulder. The abdominal and shoulder pain persisted but on the fourth postpartum day she had a bowel movement and her abdomen became less distended. A roentgenogram showed a large pneumoperitoneum

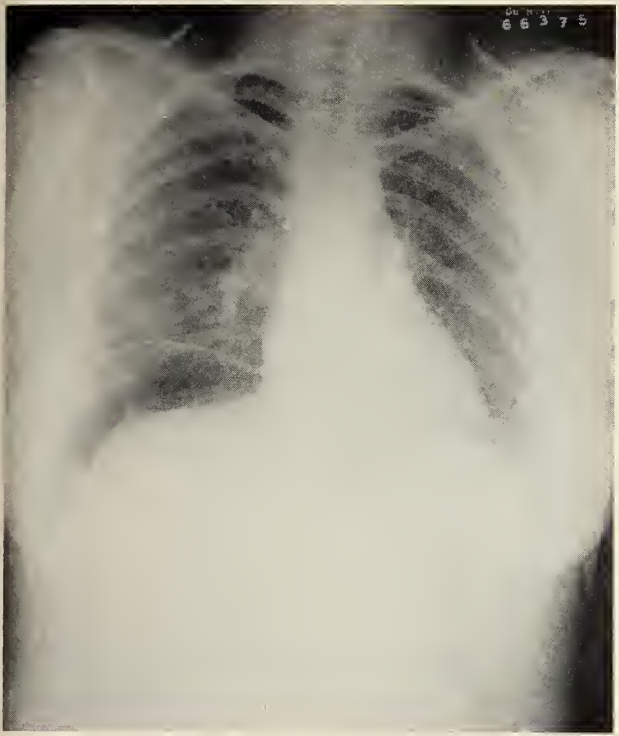

Fig. 2. Roentgenogram demonstrating large pneumoperitoneum beneath right leaf of diaphragm.

(See Figure 2). On the sixth postpartum day pelvic examination disclosed a left cervical laceration that extended to the vaginal apex. No bleeding was noted. Subsequent to this, she continued to improve daily and the abdominal and shoulder pain gradually disappeared as did the pneumoperitoneum.

She was discharged on the twelfth postpartum day. The patient remained afebrile during her entire hospital course. There was no excess vaginal bleeding. Her admitting hemoglobin was 10.4 grams and, after receiving one unit of blood, she was discharged with a hemoglobin of 9.4 grams.

However, she returned to the hospital the next day via police ambulance. She was in shock with heavy vaginal bleeding. Immediate laparotomy revealed both old and recent blood in the abdomen. There was a 7 cm. rupture of the lateral wall of the uterus with extension into the left broad ligament, and into the peritoneal cavity.

A total abdominal hysterectomy was performed. An abscess developed in the area of the left broad ligament. Her postoperative course was febrile until the eighth day when this abscess ruptured spontaneously. Subsequently she did well and was discharged on the seventeenth postoperative day.

COMMENT

The fact that free air was noted under the diaphragm on the fifth postpartum day indicates that the uterine rupture was complete, and probably occurred at the time of the spontaneous delivery of the macerated infant. Why the patient did not go into shock before the thirteenth postpartum day cannot be answered. Therefore, this is a case of complete rupture of the gravid uterus with hysterectomy delayed for 13 days.

DISCUSSION

In addition to the two cases just described, there are sporadic case reports in the literature describing similar delays in treatment with survival of the mother. Millar describes a 37-year-old para 4 who labored for two days until she delivered a dead fetus. Following the delivery, vaginal examination revealed a rupture and an immediate laparotomy was done. This revealed old and recent blood in the abdomen with a posterior rupture identical to that described in our Case 1.

Menon describes an African woman who "walked into the hospital with a ruptured uterus, an arm prolapsed outside the vulva, and no sign of shock being evident." No follow-up is given in this paper. Devi describes the rupture of a 34-week pregnancy with extrusion of the fetus into the bladder. Here there was a delay of 26 hours before hysterectomy.

The preceding have all been dramatic cases, but occasionally ruptures are surprisingly discovered when laparotomies are done for other reasons. Cummin presents a 24-year-old para 4 who was operated on for intestinal obstruction 36 hours after her pain began. An unsuspected one and one-half inch rupture was found in the fundus of the uterus. Mendel and Bone describe two cases of ruptured uteri discovered when routine tubal ligations were done about 24 hours after delivery. In none of these patients was shock noted preoperatively.

Abdominal pregnancies have also been described as the occasional end result of uterine rupture. Bodowy presents the case of an abdominal pregnancy in which the placenta was implanted along the uterine defect. Gepfert describes a rupture in a low flap cesarean section scar with extrusion of contents and a secondary abdominal pregnancy. Even more remarkable is a report by Walker of a 30-year-old African para 2 who collapsed after six days of hard labor. She was unconscious and unattended for 24 hours. The fetus was not born. Two and one-quarter years later laparotomy showed a lithopedion with an attached placenta and a rupture through the fundus of the uterus.

Therefore, although rupture of the gravid uterus is usually a castastrophic event that requires immediate treatment, this is not always true. Conceivably, it can lead to delayed shock or to secondary abdominal pregnancies or even to lithopedion formation. That Mendel and Bone found two unsuspected ruptures during routine tubal ligation indicates that this accident may be more common than previously thought.

SUMMARY

1. Two cases are presented of complete rupture of the term gravid uterus with survival of the mother despite a long delay before hysterectomy.
2. Cases of similar nature are presented from the literature.

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A first medical office tower and a low rise servic building, two of a dozen structures planned for th Professional Plaza in the Detroit Medical Center were opened formally in April. The more than 3 doctors already located in the building include spe cialists in surgery, obstetrics and gynecology, interna medicine, plastic surgery, thoracic surgery and psychiatry as well as general practitioners, radiologist and dentists.

NEW PARKE DAVIS ITEM

Parke, Davis & Company has added disposabl examination gloves to its surgical dressings produc line. The new gloves, available in both sterile an nonsterile packages, are coded for size in paste shades — pink for small, blue for medium, and gree for large.

The gloves are seamless and have long, wrist-hugging cuffs with strong rolled edges to preven tearing when putting on.

LEARNING EXPLOSION

The American public today is certainly the mos learning-minded public that has ever existed any plac at any time. The learning industry, in all its aspects is expanding so rapidly that it bids fair to play th role in our society which the railroad industry did i the late nineteenth century or the automobile industry has been doing during the twentieth century.

Eric F. Goldman
Historian, Writer, Teache
Princeton University

ORIGINAL SCIENTIFIC ARTICLE

TWO ARTICLES ABOUT MATERNAL HEALTH COMMITTEES:

The Michigan Committee On Maternal Health

By William W. Jack, M.D.
Grand Rapids

For over 30 years the Committee on Maternal Health of the Michigan State Medical Society has concerned itself with making childbirth ever safer for mother and baby. The committee is, and always has been, an instrument of continuing education for doctors of Michigan. As the years have passed the activities of the committee have broadened in keeping with the expanding body of knowledge, in keeping with many areas of interest that are complementary to the basic field of "maternal health."

Some of the activities of the committee follow.

Maternal Mortality Study

Since 1950 the committee, with the excellent cooperation of the Michigan Department of Public Health, has carried on a maternal mortality study in which the facts surrounding each maternal death in the state have been gathered, studied, and evaluated. The actual gathering of the data has been done by the various regional visiting obstetricians. The accumulated material has been used for teaching in our medical schools. Several scientific papers have been published. More recently, a series of regional committees have been established throughout the state so that an ever-increasing number of physicians may participate in the discussion of this material. This material now includes almost 2000 case histories.

Maternal Mortality Tissue Registry

In 1958, a Maternal Mortality Tissue Registry was established under the direction of A. James French, M.D., Professor and Chairman, Department of Pathology, University of Michigan Medical Center. To this registry, physicians of the state have been invited to send autopsy material from all maternal deaths. The collection now has over 400 cases. This material is available to any physician who wishes to use it. The material is also the source of scientific papers covering causes of maternal deaths and changes in the maternal organs due to pregnancy.

Medical Liaison

The committee has offered assistance to any medical group within the state that seeks a speaker on the subject of maternal health, and it stands ready to continue this service.

The committee has published a series of "Desk Reference Cards" which bring to the practicing physician up-to-date information on several aspects of obstetrics and its complications.

The committee recognizes that much of its effectiveness lies in the interest and support that arise at local and county levels.

Lay Education

The committee has always supported expectant parent education classes throughout the state and has participated in many workshops for these instructors presented by the Department of Public Health.

Perinatal Mortality and Morbidity

The committee recently has approved a greatly simplified program to encourage the analysis of perinatal deaths in each hospital throughout the state, with the expectation that as this develops it may be expanded to include perinatal morbidity. This period of life has not enjoyed the same dramatic improvement as has been true for maternal mortality, and it is deserving of the interest of all physicians who care for the mother and her baby. The Department of Public Health and the Commission on Professional

The Author
William W. Jack, M.D.

Doctor Jack is Chairman of the Michigan State Medical Society Committee on Maternal Health.

and Hospital Activities of Ann Arbor are cooperating in this new program which began in 1966.

Conference on Maternal and Perinatal Welfare

Since 1962 the committee has sponsored an annual conference on maternal and perinatal welfare. Obstetricians, generalists, pediatricians and pathologists are invited to present material of interest to all at this common forum. These meetings are increasingly well attended. The most recent meeting was held in Flint with the support of the Clara Elizabeth Fund.

The County Committee For Maternal Health

By James E. Harryman, M.D.
Muskegon

Throughout the history of the Michigan State Medical Society Committee on Maternal Health, many excellent programs have been suggested. No one, however, has consolidated these programs as an outline for the County Committees for Maternal Health. It is with this in mind that the following is presented. The aims of the MSMS Maternal Health Committee will be better accomplished if this information is available to the county committees throughout the state. All this should result in improving the maternal health care within the state of Michigan, our primary goal.

It is advisable that the chairman of the County Committee for Maternal Health be chosen from those who have a vital interest in maternal health, be he specialist or generalist. Enthusiasm is a prime requisite to initiate desirable programs in the face of apathy or inertia which may be met among one's peers, lay educators and the lay population. The proper selection of his committee is just as vital.

The committee's first duty is to improve the high level of maternal health care which now generally exists in this state. This is best accomplished by encouraging superior prenatal care and properly regulated obstetrical units. Whether the hospital regulations are adequate or not can be determined by following the suggestions made in the following publications:

1. "A Manual of Standards in Obstetric-Gynecologic Practice," published by the American College of Obstetricians and Gynecologists.
2. "Minimal Standards for Hospital Units," by the Michigan Department of Public Health.
3. "Standards for Hospital Accreditation," by the Joint Commission on Accreditation for Hospitals.

Further corrections of any faulty rules or procedures can be determined by consultation with the Department of Public Health which is always available and extremely helpful.

The committee should also be sure that liberal use of the available local obstetrical consultants is made and that consultation is mandatory in any complicated obstetrical condition.

If no committee for the review of maternal morbidity and mortality exists in the local hospitals, then this function properly falls in the province of the county committee. The purpose is to make critical analyses of the cases and to stimulate interest among all the physicians associated with these cases. This type of review should never be considered as punitive, only enlightening.

Furtherance of good obstetrical care can be enhanced if hospital administrators are persuaded to participate. A special subject such as maternal health needs special understanding. Obstetrical nurses should be encouraged to take intramural courses. Hospital funds should be made available. Once trained nurses are available, they should be encouraged, with funds and good will, to participate in extra mural courses such as those provided by the sectional meetings of the American College of Obstetricians and Gynecologists and by the Michigan Department of Public Health.

Maternal health among the indigent can be a thorny problem, but there is no reasonable excuse to turn one's back upon it. No community is without such a problem and it rightly falls within the Maternal Health Committee's jurisdiction to solve it —*and now!* The protocols of this state's Maternal Mortality Study include much too often the statement, *"no prenatal care."* The physicians cannot accept the entire blame, but it is the county committee's duty to see that good maternal care is available and to work with the local health department to bring the indigent to the available prenatal clinics.

Dissemination of professional information to those practicing obstetrics is a prime function of the committee. Regular bulletins from the Michigan State Medical Society Maternal Health Committee and the Department of Public Health are sent to the county

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Doctor Harryman is chairman of the Muskegon County Medical Society committee on Maternal Health and a member of the MSMS Committee.

chairman. The chairman, as well as all physicians practicing obstetrics in the state, receive Desk Reference Cards outlining various aspects of obstetrical care. These reference cards have been thoughtfully evolved by the State Society Committee. Through the participation of the state's leading medical educators, we are assured of furnishing the latest in accepted treatment. The county committee can do much to see that this information is generally understood and accepted.

The Michigan Department of Public Health Consultants for Maternal and Child Welfare is most cooperative in sending timely bulletins regarding new state regulations, laboratory procedures available, etc. Again this alerts the county chairman, who should see that the interested people have this information.

One of the most pleasurable of all functions of the committee is the day when enough interest is manifested to form a local Subcommittee for Maternal Mortality Studies. This group consists of *all* interested physicians, but as a minimum the committee should have several obstetricians, an internist, an anesthesiologist, and a pathologist. The consultant from the Department of Health, usually meets with all groups and is always a welcome participant. There is nothing which stimulates more interest in maternal health on the county level than these extremely valuable meetings.

Whenever a maternal death occurs in the community, a comprehensive summary, a protocol of the autopsy, and representative tissues should be sent to Dr. A. James French, M.D., at the University of Michigan Department of Pathology as a valuable addition to the Maternal Mortality Tissue Registry. Color transparencies of the specimens at autopsy are also greatly appreciated.

Last, but not least, the county committee is obligated to present a working agenda for the year to the county society president. In this agenda, the society should be persuaded to present maternal health topics of current vital interest at county society meetings. Recent discussions at the state committee level reveal that there is little comprehension of what constitutes a proper premarital examination, the necessity for Papanicolaou's smears, and the use of progestins. It is absolutely essential, of course, that the County Society Executive Committee back all programs presented.

Now that we have considered the passage and reduced all maternal morbidity and mortality to an irreducible minimum, it is time to consider the passenger. It's the committee's duty to encourage infant and perinatal mortality and morbidity studies in the county hospitals. This also will reveal some chinks in our armour of infallibility: faulty prenatal care and faulty obstetrical technique. A pilot program for perinatal mortality study is furnished in "Perinatal Mortality Study Guide" by the Michigan Department of Public Health, and by "Perinatal Study" of the American Medical Research Foundation of Philadelphia.

Lay education programs are an important part of the county plan, but must receive the wholehearted backing of the county physicians. Physician speakers should be furnished on request. Expectant parent classes, emphasizing the natural method of childbirth, are an example of public acceptance long before they were grudgingly accepted by physicians. The foremost group in this state was supported by the Clara Elizabeth Fund of Flint under the direction of Mr. David Treat. In my own community, the Visiting Nurses Association has been most active in this regard, and in other communities, hospitals and private organizations have established programs. Although hard to evaluate scientifically, most of us feel these programs are an extremely desirable part of the lay education program. Explicit detailed instructions can be found for the establishment of this type of program in the State Health Department's "Preparation for Childbirth: Teaching Manual."

Human reproduction courses for schools of the county should be encouraged. Most educators are receptive to the suggestion. Excellent programs are underway in Flint, Lansing and Jackson. These communities are most generous in forwarding copies of their programs. These contain details which help avoid the usual growing pains. References are made to all teaching materials and where they are available. Miss Alice Beckwith, R.N., of the Michigan Department of Health, stands ready to help.

Classes of a similar nature for adults and the about-to-be-marrieds fall well within the realm of the committee. In Muskegon, we willingly supply speakers to the YMCA, which has the only coordinated program of this sort for adults wanting to know the facts of life.

In view of the population explosion, Planned Parenthood organizations should be encouraged. Although this name, unfortunately, is repugnant to some groups, it should be made clear that all types of family planning are discussed — *including rhythm control.*

The committee should stand ready to discuss controversial subjects — but by experts and excellent public speakers, if possible. We do need to bring in national figures to speak in public forums on pressing issues related to maternal health.

If these programs outlined appear to be ambitious, we are the first to admit they are. However, one or many of these programs have already been initiated in many of the counties throughout the state. These counties stand ready to help with the formation of any one of these programs. The State Maternal Health Committee and the State Department of Public Health will also give as much help as possible.

Says PG Program Has PR Pluses

By Roy M. Goethe, M.D., Midland

The postgraduate medical education program of the Midland County Medical Society has existed in its present form for approximately 12 years.

It began on a very informal basis. It first consisted of live case presentations to a group of University of Michigan professors, followed by hunting and fishing expeditions to a local Sportsmans Club.

* * *

MOST INSTRUMENTAL in initiating these clinic days were Dr. Harry A. Towsley, and Dr. Wilbur Towsley, who is at present in his 44th year of practice in Midland. These Clinic Days have been known by various names: The Ann Arbor Clinic Days, Harry and Wib Towsley Days, and as the University of Michigan Postgraduate Days.

Within the past few years the present program has been included in the formal MSMS Postgraduate Education Program. The format is essentially unchanged. Live case presentations are given from 2:00 to 5:30 p.m. followed by a dinner at 6:30, and finally, by a talk given by one of the visiting professors. An attempt is made to present cases of broad general interest, and two or three are presented by each visiting professor.

With very little variation, the group of visiting Ann Arbor professors include the following: Drs. Reed Dingman, Plastic Surgeon; Earl Wolfman, General Surgeon; Walter Work, Ear, Nose and Throat; Bruce Fralick, Ophthalmologist; Arthur Curtis and Richard Harrold, Dermatologists; Reed Nesbitt, Neurologist; John Sheldon, Allergist; and William Robinson, Internist.

* * *

IN ADDITION to the educational value of this program, we feel there are also definite public relations benefits. The Clinic Day is preceded and followed by publicity in the local newspapers, radio and television.

The amount of public discussion related to this Clinic in non-medical groups is amazing.

Another area of public relations value concerns industry. In Midland, we are concerned with one industry, the Dow Chemical Company. The fruitful interchanges of ideas between the visiting Ann Arbor professors and personnel of the medical products division of Dow Chemical have produced many benefits for both medical and industrial professions.

Community Health Week Set for Fall

The annual Community Health Week, started several years ago by the American Medical Association, will be observed in Michigan and across the nation, October 16-22.

The MSMS Public Relations Committee and The MSMS Council have approved early plans to invite the Michigan Health Council and the Michigan Association of the Professions to assist again in the special week.

As in the past, MSMS and the two cooperating groups will carry out state-wide activities and also recommend various projects for county medical society consideration.

List Directors On MD-PAC Board

The MD-PAC Board of Directors has been reorganized and plans important work in the Michigan fields of political understanding and action.

The members of the MD-PAC Board of Directors are:

District Members, from Wayne County: Wyman C. C. Cole, Jr., M.D., Chairman; Robert A. Sobel, M.D.; Lionel F. Swan, M.D.; George L. Reno, M.D.; Michael J. Brennan, M.D., and Brock E. Brush, M.D. District 2: H. A. Towsley, M.D. District 3: Robert H. Hume, M.D. District 4: John P. McLelland, M.D. District 5: Albertus J. Hoffs, M.D. District 6: Harold Niekamp, M.D. District 7: George R. Anthony, M.D. District 8: Vernon V. Bass, M.D., Secretary-Treasurer. District 9: John C. Wohlrabe, M.D. District 10: Orlen J. Johnson, M.D. District 11: Louis F. Hayes, M.D. District 12: E. A. Rinkenberger, M.D. District 18: Thomas G. Varbedian, M.D. District 19: Everette Gustafson, M.D.

Members At Large: Donato F. Sarapo, M.D., Adrian; Phillip F. Lange, M.D., Lansing; Eric T. Lincke, M.D., Marquette; William T. Davision, M.D., Port Huron; George T. Kelleher, M.D., Battle Creek.

Representing the Auxiliary: Mrs. N. T. Pasternacki, Detroit.

HONORED BY EXCHANGE

E. O. Barstow, M.D., Midland, was presented the Midland Exchange Club's Book of Golden Deeds Award recently. He was cited for his contributions and dedication to local civic affairs.

MSMS United in Support Of Slagle for AMA Board

MSMS members are eagerly looking forward to the AMA Convention in Chicago, June 26-30, when they will support George W. Slagle, M.D., Battle Creek, for the AMA Board of Trustees.

The MSMS delgates to the AMA will direct a vigorous Michigan campaign. Wm. A. Hyland, M.D., MSMS Treasurer and delegation chairman, reports that considerable support has been found across the nation.

Letters and printed brochures have been mailed to all AMA delegates and state medical society officials.

Doctor Slagle, a past president of MSMS and the Calhoun County Medical Society, has long been active in AMA work. At the AMA level alone, his outstanding record of leadership includes:

—Member, AMA Advisory Committee on Physician Participation to Social Security Administration (Medicare) 1965-
—Member, Committee on Insurance and Prepayment Plans, 1959-
—Vice-Chairman of CIPP, 1963-
—Council Representative, 1962-65
—Member, Committee on Medical Practice, 1962-
—Member, Council on Medical Services, 1962-
—Member, Liaison Committee, Council on Medical Education and Council on Medical Services
—Member of numerous reference committees of AMA House of Delegates

The Michigan Delegates to the AMA are: Sidney Adler, M.D., Detroit; Ralph R. Cooper, M.D., Detroit; John R. Heidenreich, M. D., Daggett; William A. Hyland, M. D., Grand Rapids; Chairman Luther R. Leader, M.D., Birmingham; Robert E. Rice, M.D., Greenville; George W. Slagle, M.D., Battle Creek, and Donald N. Sweeny, Jr., M.D., Detroit.

GEORGE W. SLAGLE, M.D.

The Alternate Delegates are: Wyman C. C. Cole, Sr., M.D., Detroit; Otto K. Engelke, M.D., Ann Arbor; Bradley M. Harris, M.D., Ypsilanti; Oliver B. McGillicuddy, M.D., Lansing; Gilbert B. Saltonstall, M.D., Charlevoix; and Joseph A. Witter, M.D., Highland Park

Section Delegates to the AMA House of Delegates' session in Chicago in June are: John M. Sheldon, M.D., Ann Arbor (Allergy); Clarence S. Livingood, M.D., Detroit (Dermatology); Harold F. Falls, M.D., Ann Arbor (Ophthalmology); and Edgar E. Martmer, M.D., Harper Woods (Pediatrics). H. Marvin Pollard, M.D., of Ann Arbor is the Alternate to the Section on Gastroenterology.

MSMS Members serving on the Reference Committees are: Wm. A. Hyland, M.D., of Grand Rapids and Harold F. Falls, M.D., of Ann Arbor, members of the Reference Committee on Executive Session; and Donald N. Sweeny, Jr., M.D., Detroit, who will serve as a member of the Reference Committee on Legislation and Public Relations.

DETROIT—Albert Paquin, M.D., of University of Virginia, was the featured speaker May 11 at the Resident Day Program of the Detroit Branch of the American Urological Association in Detroit.

WCMS Installs Brush; Bicknell Elected; Danforth Renamed

Brock E. Brush, MD., was installed May 2 as the president of the Wayne County Medical Society, to succeed F. P. Rhoades, M.D.

In his inaugural address, Doctor Brush offered a list of 12 areas of concern for the physicans to consider.

"We, as a profession, have had thrust upon us a responsibility of our fraternity. It is our responsibility to cooperate fully in an attempt to make Medicare work by guarding against all the ills and abuses which are frequently inherent in the bureaucratic governmental control of any endeavor.

"Some of the areas which it will be our duty to scrutinize carefully are the following:

1. The doctor-patient respect and relationship.
2. The quality of care.
3. Overutilization.
4. Enlarging bureaucracy.
5. Unwarranted charges.
6. The convalescent and nursing home aspects.
7. Misinformation.
8. Governmental waste.
9. The limitation of private enterprise and energy.
10. To create enthusiasm for young physicians, nurses, etc. (recruitment).
11. The need to interest physicans in community affairs.
12. Guardianship of our heritage in medicine.

"It can be seen from this list that the opportunities for M.D.s to serve their profession was never greater. We must see and work beyond our own little area of private practice. If we do not develop medical statesmen the erosion of ideals and position will continue at an accelerated rate."

In the recent WCMS election, Frank B. Bicknell, M.D., was chosen President-Elect, and J. C. Danforth, M.D., renamed Secretary.

Pendy Leads WSU Alums

John M. Pendy, M.D., left of Detroit, receives the gavel as president of the Wayne State University School of Medicine Alumni Association at the recent annual meeting, from Marion W. Jocz, M.D., of Detroit.

On May 6 the WSU School of Medicine presented its 98th Annual Clinical Program and alumni reunion banquet at the Sheraton-Cadillac Hotel in Detroit.

The 14 surviving members of the Class of 1916 were especially honored as well as members of the faculty and outstanding members of the student body.

Plan 1 Request For H-C-S

Plans are being drafted for a separate corporation to administer a statewide attack on heart disease, cancer and stroke.

The corporation would seek federal funds for one of the regional programs authorized last year by Congress at President Johnson's urging.

Present plans are to establish a board of directors with representatives of the Michigan State Medical Society, Michigan Hospital Association, Michigan Health Council, State Department of Health, the University of Michigan, Wayne State University and Michigan State University. No single organization would dominate the board or the program.

Proposed articles of incorporation are being circulated among these organizations for approval.

Health Technology Careers Promoted For Junior Colleges

The "hottest item in the junior college educational inventory today is the health technology field, according to Norman C. Harris, University of Michigan professor of technical education.

"Plagued by a shortage of doctors and nurses for over a decade, the health manpower situation is now being exacerbated by the impending advent of Medicare and other Great Society programs," Harris said in a speech in St. Louis, Mo. recently. He has urged community junior colleges and technical institutes to help train the thousands of needed registered and practical nurses, medical lab technicians, x-ray and electrocardiogram technicians, and technicians to support medical research.

Coller-Penberthy-Thirlby Speakers Set July 28-29

Nationally known medical educators have been secured for the 46th Annual Coller-Penberthy-Thirlby Medical Conference at Traverse City, July 28-29.

All Michigan Physicans are invited to participate in the conference at the Park Place Motor Inn. Details may be obtained from James W. Hall, M.D., Munson Medical Center, Traverse City.

The program for Thursday, July 28 will include addresses by William A. Altemeier, M.D., Cincinnati; Mark A. Hayes, M.D., New Haven, Conn.; Carl E. Badley, M.D., Walter P. Work, M.D., Arthur C. Curtis, M.D., Reed M. Nesbit M.D., Harry A. Towsley, M.D., all of Ann Arbor; G. Thomas McKean M.D., Clifford D. Benson, M.D., A Martin Lerner, M.D., all of Detroit and Lester R. Dragstedt, M.D. Gainsville, Fla.

The evening banquet, with U-M Dean William N. Hubbard, Jr. M.D., as toastmaster will feature Charles Hudson, M.D., who then will be the President of AMA.

Speakers for July 29 include William D. Robinson, M.D., Robert B Sweet, M.D., Edgar Kahn, M.D. all of Ann Arbor; Merle M. Musselman, M.D., Omaha; and Marion S. DeWeese, M.D., Columbia, Mo The afternoon will include a gol tournament, ladies' luncheon and fashion show, boat cruises, fishing etc.

Professor Harris points out also that, "Although smaller number are involved, the need is nonetheles critical for dental technicians, histologic technicians, inhalation therapists, and psychiatric technicians."

McLean Honored

At the WSU 98th Reunion May 21, Don W. McLean, M.D., Lathrup Village, was among seven distinguished graduates to receive Alumni Awards. Doctor McLean, Class of 25, is a MSMS Councilor and past president of the Wayne County Medical Society. He has long been prominent in WSU Alumni Association and fund-raising activities.

GRAND RAPIDS—The Liberty Bell Award has been presented by the Grand Rapids Bar Association to Edward A. Jones, Jr., M.D., in recognition of his community leadership. An internist, he is active in the NAACP and Urban League.

Disseminators

DETROIT — Fifteen Wayne County agencies have joined together to collect and disseminate factual information about the relationship of smoking to health and disease.

The organization will be known as the Wayne County Council on Smoking and Health. It is the local affiliate of the Michigan Council on Smoking and Health.

Robert R. Luby, M.D., divisional director of the Health and Physical Education Department, Detroit Public Schools, is chairman of the Wayne County group.

Taheri, Bay City, Gives Foster Lecture

BAY CITY—The 9th Annual Education Seminar of the Michigan State Medical Assistants Society was held in Bay City.

Robert M. Heavenrich, M.D., Saginaw, spoke on "Immunizations." "New Techniques in Thoracic Surgery" was the title of the speech of John L. Shek, M.D., Saginaw.

The L. Fernald Foster Lecture was presented by A. E. Taheri, M.D., Bay City. Doctor Taheri illustrated "Spinal Surgery and New Techniques in Spinal Fusions" by the use of slides. He explained how spinal fusions are performed through the abdomen rather than through the back and showed us how bone plugs are used in this procedure.

Four of the MSMAS Advisors were present for the day—G. E. Millard, M.D., Detroit; F. C. Cretsinger, M.D., Kalamazoo; W. T. Davison, M.D., Port Huron; and T. J. Trapasso, M.D., Sault Ste. Marie.

The 9th Annual Education seminar was under the chairmanship of Mrs. Pauline Moore.

Stresses Essential Role Of Newspaper Reporters

Michigan newspaper reporters, editors, medical writers, physicans and professors participated May 5 in the Conference on Medical News Reporting at Michigan State University. MSMS was one of the major co-sponsors.

The role of the medical writer was lauded by Roger S. Mitchell, M.D., Denver, who gave the Yates Memorial Lecture in the evening. He pointed out that "All too often the reasons why citizens do not react intelligently is because they lack adequate and accurate knowledge."

Doctor Mitchell declared, "We rely upon you to convert what we say into words intelligible to the average citizen.

"I want to emphasize how essential a role you science writers play in the important business of communicating scientific facts to the public. It is a difficult and important task and one which I am sure you regard with the greatest respect and pride."

Doctor Mitchell, a cancer researcher, discussed "Meeting the Challenge of Chronic Respiratory Disease."

Featured speaker at the Conference on Medical News Reporting at MSU was Roger S. Mitchell, M.D., third from left, who is shown with other morning speakers, left to right, Dean Andrew D. Hunt, Jr., M.D., MSU College of Human Medicine; E. O. Coates, Jr., M.D., Detroit; and James Stokley, MSU professor of science writing at far right.

A benefit art show, to aid the Herman Kiefer branch of the Detroit General Hospital, was enjoyed by, left to right, William Wertz, M.D., Detroit; Mrs. Samuel Danto, chairman; Mrs. George Romney, and Kenneth Pitts, M.D., Detroit.

Show Benefits Kiefer Hospital

"It seems most appropriate that the art of medicine and art itself should be brought together to benefit people struggling to find the art of living," declares K. E. Pitts, M.D., Director of the department of psychiatry at Detroit General Hospital.

Doctor Pitts was co-chairman of the committee of physicans on the staff of Detroit General Hospital's department of psychiatry that sponsored an art show at Wayne State University's Community Arts Building, May 6-8.

The show featured the work of Michigan artists. Proceeds from the sale of the paintings will help to extend the facilities for emotionally disturbed children at the Herman Kiefer branch of the Detroit General Hospital.

As Dr. Alfred Golden, the medical contacts chairman of the show, put it, "The children have the necessities. Now they need some of the trimmings, the things which will make the hospital as much like a home as possible."

Healthmobile Wins Plaudits In Wisconsin

The State Medical Society of Wisconsin, in hosting our MSMS Healthmobile at its recent annual meeting, described in part the health-museum-on-wheels to their members as follows:

"We feel that you will be particularly interested in the Healthmobile, as, besides its general health education functions, it is intended to recruit students into the health field.

"The exhibits give a comprehensive picture of medicine today, as well as showing what medical education was like in earlier days. But in addition, the Healthmobile stresses the importance of medical science in the future, and the rapid expansion of careers in the health field."

The Wisconsin doctors were generous in their praise when they saw the unit.

MSMS Presdent Luther R. Leader, M.D., was an honored guest at the Wisconsin convention. Ralph Wills, MSMS director of community relations, accompanied the Healthmobile, which is now swinging across the Upper Peninsula from Ironwood, Houghton, Marquette, Escanaba, Menominee, Iron Mountain and Sault Ste. Marie. It will leave the Soo June 25 and then visit cities in the northern portion of the Lower Peninsula.

Strong Program At Irom Mountain

Perhaps the strongest program ever is offered for the Upper Peninsula Medical Society meeting, June 17-18, at Iron Mountain.

The May issue of MICHIGAN MEDICINE listed Governor Romney as the 4 p.m. speaker June 17; AMA President Appel as the dinner dance speaker, June 18; MSMS President Luther R. Leader on the program both days etc.

Following is the list of out-of-state speakers for the 73rd annual program:

June 17 — M. Edward Davis, M.D., Chicago, on Menopause; W. B. Seaman, M.D., New York City, on Diagnostic X-ray; R. J. Samp, M.D., Madison, on Quackery; R. A. Kyle, M.D., Rochester, Minn., on Leukemia; F. M. Forester, M.D., Madison, on Epilepsy.

June 18—all Michigan speakers, except Doctor Appel.

Annual Session In GR to Offer Stellar Speakers

Michigan physicans participating in the 1966 Annual Session in Grand Rapids, September 27-28-29-30, will hear many outstanding medical authorities from across the nation.

The first list of speakers is announced by Chairman Harry A. Towsley, Ann Arbor.

The following noted out-of-state physicans have accepted invitations already to speak:

Ben Eiseman, M.D., Lexington
John Masterson, M.D., Chicago
M. Lois Murphy, M.D., Houston
George Burch, M.D., New Orleans
Paul W. Greeley, M.D. Chicago
C. Thomas Flotte, M.D.
Baltimore
L. Stanley James, M.D.
New York City
Russell B. Roth, M.D., Erie, Pa.
Robert G. Siekert, M.D.
Rochester, Minnesota

18 BIG MONTHS

By Frank C. Coleman, M.D., Chairman, American Medical Political Action Committee

Not too long ago I had a call from a writer on one of the nation's major publications.

"I just called you," he explained, "to find out whether AMPAC had dried up and blown away since the passage of medicare."

"Not exactly," I said. "Membership is up 50 per cent over the previous high. Candidate support committees are already at work in dozens of districts. The small cadre of politically experienced physicians on which this activity was built has grown to an incredible degree. And instead of spending three-quarters of their time recruiting members, our PAC leaders are now able to concentrate on helping candidates win."

All of which seemed to come as news to him.

But when you stop to think of it, medical-political action has limited visibility for perhaps 18 out of 24 months. At least, those outside of medicine don't see very much to suggest that we are still in business, will remain in business, and won't dry up and blow away just because our profession has suffered a legislative defeat.

But those 18 off months are when the real work is done. This is the period when organizations are strengthened, political data are gathered, new leaders are discovered, prospective candidacies are weighed, non-medical allies are acquired, political education is furthered—all to the end that we will be ready to go when the time comes.

Medicare? Its passage was totally predictable Election Day Plus One, 1964. All we didn't know was when it would pass, and what its final form would be.

It didn't take very long to find out.

Nor will it take very long to find out how this basically unsound law will work, for an important part of it becomes effective July 1.

It is heartening, as I travel around the country, to find so few of our colleagues under the misapprehension that this is the end of federal encroachment into medical practice—at least for the predictable future.

It is, of course, only the beginning. President Johnson is already talking about further expansions of the Social Security Act—higher pensions, broader benefits, and even a new "kiddie care" dental program for young children. These are simply straws in the wind until the 90th Congress sits down to ponder its anemometer.

But the deliberations of the 90th Congress will ultimately depend, as they always do, upon the men and women who comprise it.

And that is where AMPAC and MDPAC come in.

How effectively will we function in this campaign? How effectively will the political action committees in 49 other states do their job?

We'll know the day after the next election. And we will also know the degree to which the medical profession will be able to withstand the predictable political pressures of this Administration.

To those of our colleagues in Michigan who have not yet joined the PAC movement, we urge you to delay no longer. We who are active within it, and our profession as a whole, need every reinforcement we can get.

IT'S THE MARK OF A PROFESSIONAL

Physicians are attending "refresher courses" and postgraduate education programs at ever-increasing rates, according to the recent report of the AMA Council on Medical Education.

The number of refresher courses has increased by more than 50 per cent in the past five years.

The constant pressure to keep up with developments in clinical experience, research, drugs and equipment, is only one facet of professional life. It is a facet that has an effect on the public "doctor image."

Plan now to attend the 101st Annual Scientific Sessions of MSMS in Grand Rapids, September 27-28-29-30. You'll find details in this and future numbers of MICHIGAN MEDICINE.

NOTED AND QUOTED

William F. Schwartz, educational consultant on VD eradication for the U. S. Public Health Service:

"Six hundred teen-agers a day are contracting venereal disease. The statistic could be virtually wiped out, if schools taught the signs and available treatments for these infectious diseases. Just as the spread of plague, typhoid, malaria, and other communicable diseases has been stopped because the public is alert to the dangers, so could the spread of infectious syphilis be halted." Schwartz said only a tiny fraction of young people are being educated.

Pro-Banthine®
(propantheline bromide)

Intragastric photography has provided a new and precise method of measuring the effectiveness of anticholinergic drugs. The transition from gastric motor activity to relaxation seen with effective doses of such drugs takes only a few seconds and is easily demonstrated.

The importance of vagal stimulation of gastric hyperacidity and hypermotility makes such measurements particularly important in evaluating the parasympatholytic effect of drugs used in patients with peptic ulcer, gastritis, biliary dyskinesia and other gastrointestinal disorders.

Pro-Banthīne has been shown[1] to produce complete gastric motor inactivity with doses of 6 to 8 mg. intravenously. Comparison tests were made with the belladonna fraction, atropine. Measured usual dosage unit versus usual dosage unit, Pro-Banthīne was more than four times as effective as the belladonna alkaloid.

Indications: Peptic ulcer, functional hypermotility, irritable colon, pylorospasm and biliary dyskinesia.

Oral Dosage: Adequate dosage should be given for optimal results. For most *adult* patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type ampuls of 30 mg.

Side Effects and Contraindications: Urinary hesitancy, xerostomia, mydriasis and, theoretically, a curare-like action may occur. Pro-Banthīne is contraindicated in patients with glaucoma, severe cardiac disease and prostatic hypertrophy.

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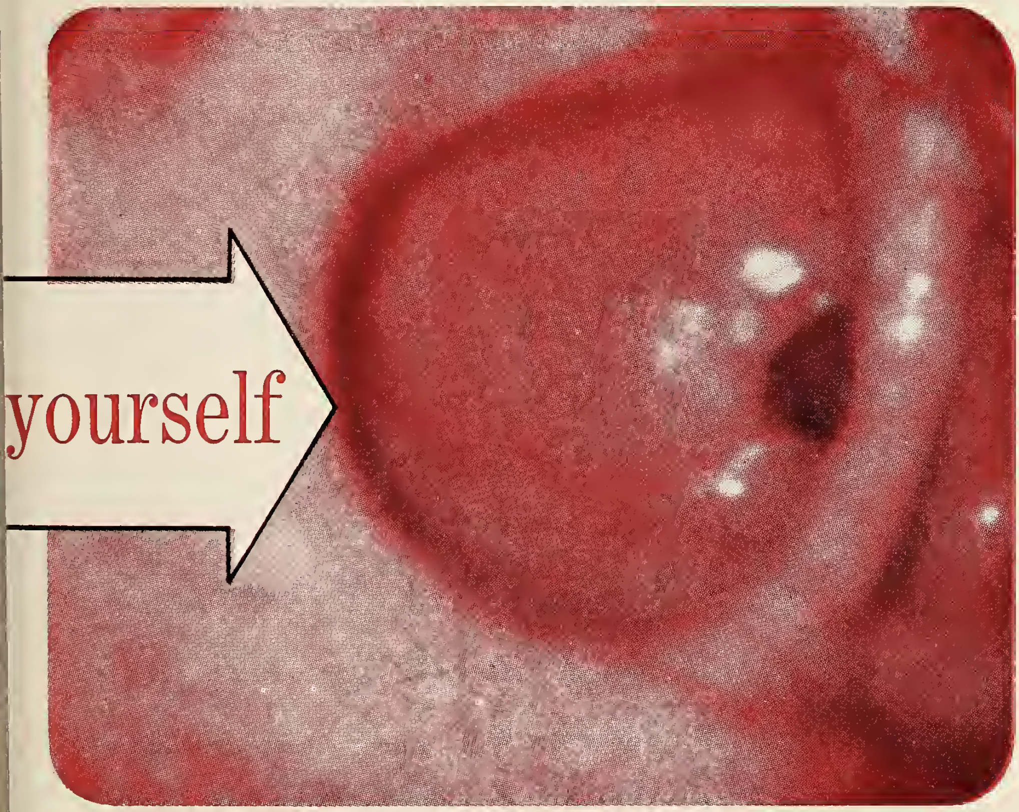
1. Barowsky, H.; Greene, L., and Paulo, D.: Cinegastroscopic Observations on the Effect of Anticholinergic and Related Drugs on Gastric and Pyloric Motor Activity, Amer. J. Dig. Dis. *10*:506-513 (June) 1965.

See for

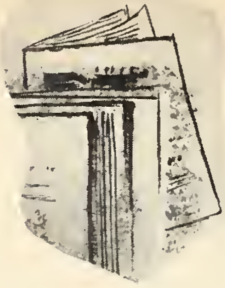
Is Effective



Complete gastric relaxation with Pro-Banthīne. As this intragastric photograph demonstrates, gastric relaxation is attained with 6 mg. of Pro-Banthīne intravenously; the antrum is relaxed and the pyloric orifice remains open. Full intravenous doses of atropine (4 mg.) produce no measurable effect.

SEARLE

Research in the Service of Medicine



Vital Information About Medicare:

With the advent of Medicare soon upon us, Michigan Medicine begins providing general information and pertinent data concerning the Medicare program, as well as other items of interest to M.D.'s and the general public. Any inquiries on the new program will be answered promptly.

The Committee on Governmental Medical Care Programs has had a number of meetings with the fiscal intermediary to arrive at a mutually acceptable arrangement for payment of physicians' services. This Committee recommended: That the 1965 MRVS at $5 conversion factor, subject to review yearly, be the guideline for physicians' payment under Titles 18B and 19, with the understanding that the customary, prevailing and reasonable fee may vary according to the physician's training, experience and geographical location. This recommendation was accepted by the County Societies Committee, which recommended that it be approved by The Council. The Council, at its April 18 meeting, approved this recommendation.

Following that, The Council recommended that A. J. Neerken, M.D., Chairman of the Committee on Governmental Medical Care Programs, and an MSMS staff representative accompany John McCabe, Executive Director of the Michigan Medical Service, to meet with the Social Security Administration. It is hoped that the Social Security Administration will approve this recommendation.

Upon further recommendation of the County Societies Committee, The Council approved the following:

1. That The Council reaffirm using the Michigan 1965 RVS with a five dollar conversion factor as a guideline (for physician payment under Titles 18B and 19);
2. That The Council reaffirm the absolute necessity of annual review of both the RVS *and* the conversion factor;
3. In consideration of the recognized variation in existing fees, and with recognition that the law permits any physician to elect to receive an assignment, The Council recommends that under Public Act 89-97 every physician deal directly with the patient in both medical care or service and in reimbursement, and that every physician should submit to the patient his own charges based on his usual, customary and reasonable fees.

MEDICARE BRIEFS:

AMA has announced that a pamphlet will be published on Medicare for use by physicians shortly after all regulations have been published on Public Law 89-97. Further information will appear in the next issue of Michigan Medicine.

. . . Some M.D.'s are preparing a distribution sheet for their Medicare patients explaining what Medicare will or will not cover.

. . . Expect changes for physicians who provide care for those over 65 under PL 89-97.

. . . When a physician accepts an assignment for his services, full payment will be that allowed by the Federal program.

. . . M.D.'s not accepting assignments may charge the patient whatever they wish, and the patient will be responsible for payment.

. . . Physicians may accept a promissory note and give the patient a receipted bill to use to obtain reimbursement.

. . . The University of Michigan News Service says: U of M Hospital is preparing its 3,000 employees for anticipated difficulties when Medicare takes effect July 1. Roger B. Nelson, M.D., Senior Associate Director of the hospital, said: "We do not know how many patients to expect, nor how long they must stay. The best guess today is that the immediate impact will be felt most strongly in the out-patient services." A teaching program is under way to acquaint hospital employees with the services furnished by Medicare in order that hospital employees can answer patients' questions clearly, quickly and accurately. Doctor Nelson continued: "It may take two years to get necessary decisions on some major facets of the program; other aspects of Medicare may cause confusion for four or five years before they are settled."

Commentary Offered On Medicare Rules

From "The Blue Shield"
National Association of Blue Shield Plans
April, 1966

Some idea of the extent and pervasiveness of the Federal Government's involvement in medical affairs may be gained from an examination of three Medicare documents released by HEW almost simultaneously in mid-March.

"Conditions of Participation for Extended Care Facilities" contains 85 pages of principles, criteria, procedures, standards and other forms of administrative fiat relating to the many kinds of services for the aged embraced by the term "extended care facility" as set forth in Section 1861(j) of the Social Security Act.

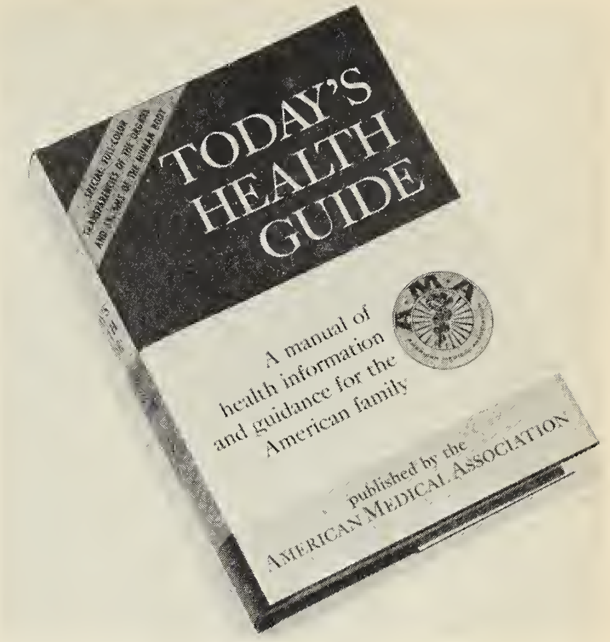
Another volume of 51 pages, titled "Conditions of Participation for Home Health Agencies" (as defined in Section 1861.o)) of the statute, sets forth the requirements to be met by such agencies as visiting nurse associations, subdivisions of local or state health or welfare departments, hospitals, medical schools, clinics, extended care facilities or rehabilitation agencies offering home health services.

The third such volume, comprising 32 pages, prescribes the "Conditions for Coverage of Services of Independent Laboratories" under Part B of Medicare. These conditions apply to diagnostic laboratories operating separately from the attending physician's office or a hospital, except that if a physician's laboratory performs diagnostic services on reference from other physicians, the laboratory would have to meet these conditions to qualify for reimbursement under Part B.

In each case these "Conditions" are later to be spelled out in formal regulations to be promulgated by HEW.

There is also evidence that HEW is seriously considering the issuance of a highly structured set of regulations governing the determination of "reasonable charges" under Part B.

In the months before July, the medical profession and the carriers would do well to be vigilant, lest the mountain of papers carry away basic liberties in a swirling stream of highly technical words.



County medical societies are purchasing copies of the AMA Today's Health Guide book for presentation to libraries, schools and other community outlets. The book, which physicians might like to have available in their waiting rooms, contains 640 pages of general advice. Copies are available at cost from the AMA at $5.95. More than 20,000 diseases, illnesses, medical conditions and subjects are thoroughly covered, with more than 300 illustrations.

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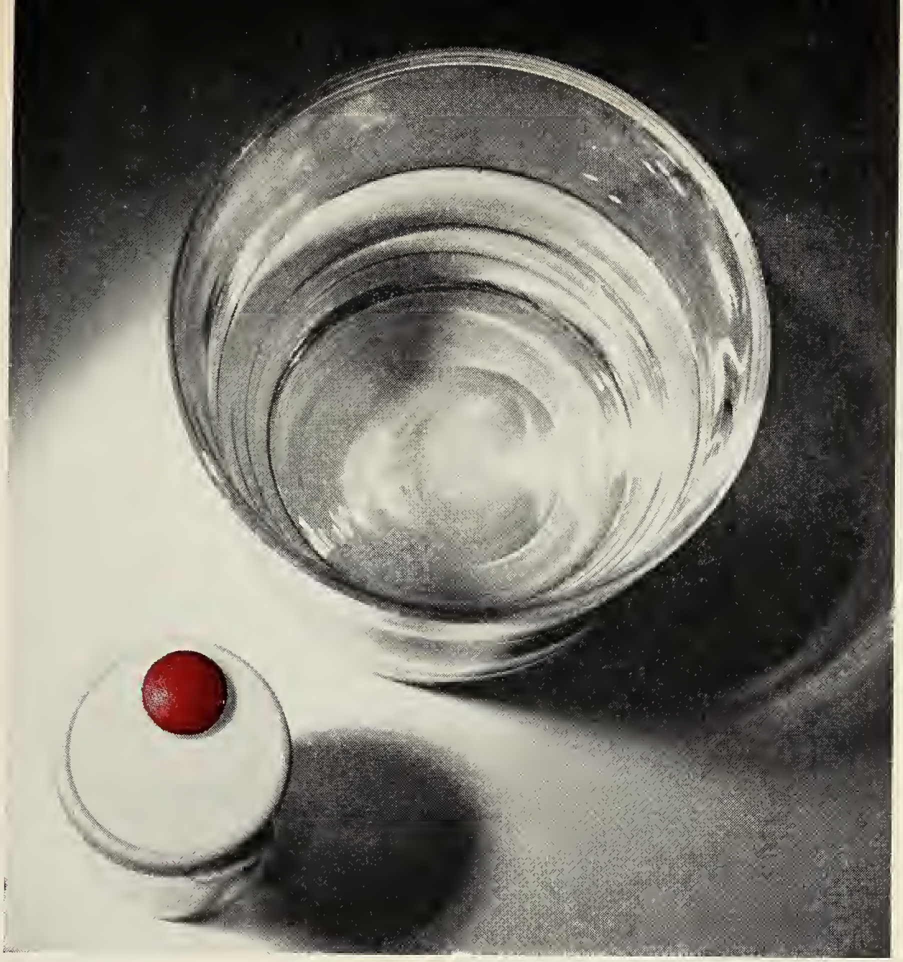
Effective in a wide range of everyday infections—respiratory, urinary tract and others—in the young and aged—the acutely or chronically ill—when the offending organisms are tetracycline-sensitive.
Contraindication—History of hypersensitivity to demethylchlortetracycline.
Warning—In renal impairment, usual doses may lead to excessive systemic accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Sma amounts of drug and short exposure may produce an exaggerate sunburn reaction which may range from erythema to severe ski manifestations. In a smaller proportion, photoallergic reactio have been reported. Patients should avoid direct exposure to su light and discontinue drug at the first evidence of discomfort.
Precautions and Side Effects—Overgrowth of nonsusceptible orga isms may occur. Constant observation is essential. If new infe tions appear, appropriate measures should be taken. Use



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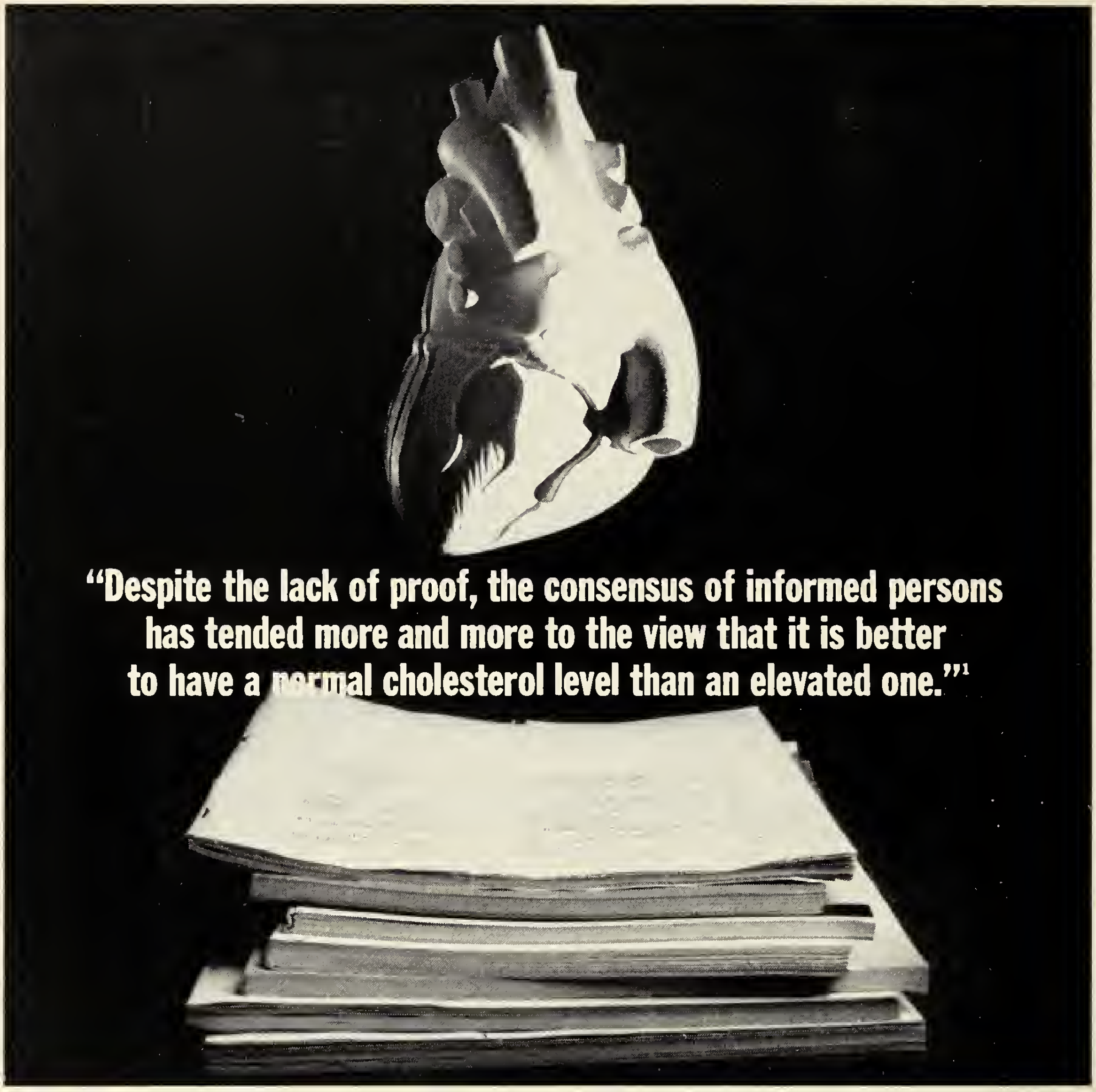
lemethylchlortetracycline during tooth development (last trimester f pregnancy, neonatal period and early childhood) may cause discoloration of the teeth (yellow-grey-brownish). This effect occurs nostly during long-term use but has also been observed in short reatment courses. In infants, increased intracranial pressure with ulging fontanels has been observed. All signs and symptoms have isappeared rapidly upon cessation of treatment. Side reactions nclude glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis nd dermatitis. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Anaphylactoid reactions have been reported.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products.

Capsules: 150 mg of demethylchlortetracycline HCl.

Tablets: film coated, 300 mg, 150 mg, and 75 mg of demethylchlortetracycline HCl.

EDERLE LABORATORIES, A Division of American Cyanamid Company, Pearl River, New York Lederle


"Despite the lack of proof, the consensus of informed persons has tended more and more to the view that it is better to have a normal cholesterol level than an elevated one."[1]

THE **DRUG** TO LOWER CHOLESTEROL...

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(ALUMINUM NICOTINATE)

☐ Reduces cholesterol by 15-30% in most patients[2]

☐ Matches nicotinic acid in effective reduction of elevated serum lipids—but with minimized tendency to cause flushing[3]

☐ Simpler, more practical than diet[1]

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Division of Richardson-Merrell Inc., Mount Vernon, New York 10551

NICALEX Prescribing Information: COMPOSITION: Each tablet contains: Aluminum Nicotinate 625 mg.—a complex consisting of (approx.): Aluminum Hydroxydinicotinate 450 mg. and Nicotinic Acid 155 mg. (Equivalent in activity to Nicotinic Acid 500 mg.) INDICATIONS: The primary indications for NICALEX (Aluminum Nicotinate) are to reduce the serum cholesterol and total lipid levels in hypercholesteremia and hyperlipemia. It may also be useful in reducing xanthomatous tissue cholesterol deposits. PRECAUTIONS AND WARNINGS: Patients with peptic ulcer, liver, or gallbladder disease should be observed closely while taking the medication. Diabetic patients may require adjustment of diet and insulin dosage in the event of decreased tolerance. Patients receiving anti-hypertensive drugs of the adrenal-blocking type should be watched for signs of postural hypotension. Occasional side effects of Nicotinic Acid in large dosage are decreased glucose tolerance (resembling diabetic-type curve) sometimes with glycosuria, temporary activation of peptic ulcer, transient jaundice, and metabolic disturbance of liver function without definite hepatic pathology. These side effects were found to be reversible upon discontinuing nicotinic acid therapy. Certain transitory skin changes have been observed with nicotinic acid therapy. These include: dryness of the skin and keratosis nigricans, particularly in axillae. SIDE EFFECTS: Administration of NICALEX (Aluminum Nicotinate) may produce temporary flushing and pruritus, also mild gastrointestinal distress, but these reactions are transient and apparently not serious. DOSAGE: The adult dose is 2 to 4 tablets t.i.d. with meals. HOW SUPPLIED: In bottles of 100 and 1000. CAUTION: Federal law prohibits dispensing without prescription. REFERENCES: 1. Parsons, W.B., Jr., Mayo Clin. Proc., 40:822, 1965. 2. Goldsmith, G.A., Amer. J. Dig. Dis., 9:651, 1964. 3. Boyle, E., Jr., J. Amer. Geriat. Soc., 10:822, 1962. U.S. Patent 2,970,082

14,000 Goldfish?

Needles, drugs and scalpels aren't all you'll find on a hospital's shopping list. Last year the University of Michigan Medical Center purchased 14,000 goldfish. The finned heroes have become important and inexpensive subjects for research into stream pollution, eye diseases and memory.

Says Most Doctors Collect 85 Pct.

By W. Fred Mangan

According to reports in several AMA publications the average doctor collects about 85 per cent of what is owed to him. This percentage fluctuates slightly from year to year, but not over 2 or 3 per cent since 1946.

The percentage is calculated by dividing a doctor's total business done into his professional receipts for a given period.

This percentage is referred to as his "collection percentage." On a monthly basis it means very little. For management purposes it becomes significant when it expresses collection results on a year-to-date basis. That is, measuring each year from January 1 to date. When most publications refer to a per cent of collections, they are referring to an annual figure. No doctor collects 100 per cent, and the typical PM client collects over 90 per cent. This is the maximum a doctor can expect to receive for his work, and it indicates a high degree of success to any collection control system. This also carries with it the implication that the doctor has good public relations and that he is maintaining the patients' good will.

How Accounts Receivable Compare to Monthly Business Done

Per Doctor	Accounts Receivable*	Monthly Business Done	Ratio Business Done Into Accounts Receivable
General Practice	$20,060	$4,455	4.4 Months
General Surgery	15,993	4,938	3.3
Internal Medicine	12,111	4,313	2.8
OB-Gyn	16,249	4,533	3.2
Pediatrics	15,126	4,066	3.7
Composite	16,597	4,754	3.5

*Averages based on statistical survey made by Black & Skaggs Associates in 1965.

**The author is associated with PM-Battle Creek, an affiliated firm of Black & Skaggs Associates, Inc.*

Health Facilities Planning Council Well Underway

With the spotlight on health care and the increased use of hospitals and related facilities, the Michigan Health Facilities Planning Council program of coordinated areawide voluntary planning for such facilities is finding interest and support in Michigan.

The organizational program began in September, 1965, and now has seven metropolitan area planning councils either established or in the organizational process. From this beginning, MHFPC expects to have five outstate regional councils within the year.

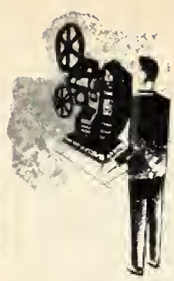
The Michigan Health Facilities Planning Council is a division of the Hospital Research & Educational Reserve of Michigan, Inc., and its statewide program is sponsored by the Michigan Hospital Association, the Michigan State Medical Society, the Michigan Association of Osteopathic Physicians & Surgeons, the Michigan Osteopathic Hospital Association, and Blue Cross.

The Michigan Health Facilities Planning Council staff is currently working with groups in Muskegon, Grand Rapids, Lansing, Jackson, Flint, Saginaw and Bay City. Regional Councils will be established to serve southwestern, west central, east central, north central and the upper peninsula districts of the state. The councils are to be made up of representatives of the health professions as well as education, business and industry, and will be responsible for orderly planning for acute care hospitals and related facilities in the region.

Areawide planning on a voluntary basis has been practiced in the United States for more than 25 years. The Greater Detroit Area Hospital Council founded in 1956 serves a six-county area in south-eastern Michigan, and today there are more than 60 such councils operating in 29 states.

Harry J. Parke is the executive director.

Babies and children have a greater chance to live into adulthood: Since 1940, the death rate for babies under one year has dropped 54 per cent; for children one to four years, 66 per cent; for children five to 14 years, down 60 per cent.



95 from U-M Intern in State

Ninety-five new doctors from the University of Michigan Medical School will begin duty July 1 as interns in Michigan hospitals.

An additional 91 new graduates will intern in hospitals outside Michigan, and four will intern in U. S. Army hospitals.

The number choosing to remain in Michigan for their internship is 12 more than a year ago. "This," said a U-M Medical School spokesman, "is a reflection of the general high quality of Michigan hospitals, not only for patient care but also in the opportunities for learning."

Of the 190 U-M seniors who took part this year in the National Intern Matching Program, 130 will be interning at the hospital they had listed as their first choice.

In Michigan, 323 of the 613 available internships were filled, leaving 290, or 47 per cent, vacant.

Wayne County General Hospital at Eloise, which filled its authorization of 36 interns, is getting 18 of them from U-M. St Joseph Mercy Hospital in Ann Arbor, which filled its authorization of 20, is getting 17 from U-M.

Fifteen U-M graduates will be among the 38 new interns at University Hospital here.

The remaining 45 U-M graduates who are staying in Michigan will be scattered among 16 hospitals from Detroit to Traverse City.

OLDEST VETERINARIAN IN STATE NOW 97

Zachery Veldhuis, D.V.M., the oldest veterinarian in Michigan, was honored during the Annual Conference by Michigan State University for his 70 years of service to the people of the state and the veterinary profession.

At the age of 97, Doctor Veldhuis of Hamilton still does some practice and meat inspection for the City of Grand Rapids.

Born in Allegan County in 1869, Doctor Veldhuis has seen much history in the making. Even though Lee had surrendered to Grant at Appomattox four years before his birth, Bell had not yet invented the telephone and Edison still had 10 years to go on his incandescent lamp.

1,814 Work in Local Health Departments

A recent inventory of local health departments in Michigan revealed that there were 1,814 full-time employees, including 46 physicians.

Today, there are local health departments in the state that are approved by and receive financial assistance from the Michigan Department of Public Health. In addition, there are a number of local health departments which are not approved and, therefore, not eligible for state financial assistance.

The number and types of people employed by these various departments vary greatly. The largest approved local health department in Michigan has over 700 people on its staff, while one of the smallest approved county units in rural Michigan has less than five full-time employees. The larger department employs a wide variety of professionals including chemists and industrial hygienists, while the smaller departments usually employ only a physician, nurse, sanitarian and clerk.

Inventory of Full-Time Health Department Personnel

Approved Local Health Departments Michigan, February, 1966.

1. Physicians	46
2. Nurses	635
3. Sanitarians	331
4. Engineers	19
5. Health Educators	12
6. Clerical	484
7. Others	287
Total	1814

More Serve Abroad

United States physicians are showing a "steady upsurge" of interest in serving people in newly developing nations in Asia, Africa and Latin America. Although it often means an 18-hour day at low pay with few medical supplies, more than 2,000 physicians now participate in such programs. One thousand inquiries a year are being received from interested medical men.

NEW DOW CORNING BOOKLET

Surgical procedures for insertion of Silastic brand rhinoplasty implants by the Safian technique are described in a recently revised data sheet just published by Dow Corning Corporation, Midland. The bulletin, #14-086, also gives properties of the material and specific advantages as well as bibliography on implanting techniques and materials. It is available from the Medical Products Division, Dow Corning Corporation, Midland.

Anatomy of
Low Back Pain #1
the sedentary life
is often the seat of
low back pain

The human spine is not engineered for prolonged sitting at desks, pianos, typewriters and drafting boards. The stresses set up by the heavy, forward-tilted head and trunk, balanced precariously on an insufficient base, result in strain of the dorsal musculature, particularly at the low lumbar level.

The unusual muscle-relaxant and analgesic properties of 'Soma' make it especially useful in the treatment of low back sprains and strains. 'Soma' is widely prescribed ☐ **to relieve pain** ☐ **to relax muscles** ☐ **to restore mobility.**

Indications: 'Soma' is useful for management of muscle spasm, pain, and stiffness in a variety of inflammatory, traumatic, and degenerative musculoskeletal conditions. It also may act to normalize motor activity in certain neurologic disturbances.

Contraindications: Allergic or idiosyncratic reactions to carisoprodol.

Precautions: 'Soma', like other central nervous system depressants, should be used with caution in patients with known propensity for taking excessive quantities of drugs and in patients with known sensitivity to compounds of similar chemical structure, e.g., meprobamate.

Side Effects: The only side effect reported with any frequency is sleepiness, usually on higher than recommended doses. An occasional patient may not tolerate carisoprodol because of an individual reaction, such as a sensation of weakness. Other rarely observed reactions have included dizziness, ataxia, tremor, agitation, irritability, headache, increase in eosinophil count, flushing of face, and gastrointestinal symptoms.

One instance each of pancytopenia and leukopenia, occurring when carisoprodol was administered with other drugs, has been reported, as has an instance of fixed drug eruption with carisoprodol and subsequent cross reaction to meprobamate. Rare allergic reactions, usually mild, have included one case each of anaphylactoid reaction with mild shock and angioneurotic edema with respiratory difficulty, both reversed with appropriate therapy. In cases of allergic or hypersensitivity reactions, carisoprodol should be discontinued and appropriate therapy initiated. Suicidal attempts may produce coma and/or mild shock and respiratory depression.

Dosage: Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

Supplied: Two Strengths: 350 mg. white tablets and 250 mg. orange, two-piece capsules.

Before prescribing, consult package circular.

for the relief of low back sprains and strains

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Dr. Adler Resigns As MMS President

Sidney Adler, M.D., has resigned as President of the Board of Michigan Medical Service (Blue Shield) after nearly five years in that post. He was elected president in October, 1961. Doctor Adler's resignation comes as a result of increasing pressures of private practice. He will serve on the Michigan Blue Shield board for the balance of his term.

During Doctor Adler's tenure, Michigan Blue Shield membership rose from about three million in 1961 to nearly four million in 1965, and benefits paid for subscribers' care rose from 82 million dollars to more than 100 million dollars in the same period.

He is a member of the Michigan State Medical Society's delegation to the American Medical Association.

Blue Shield Roles, Benefits at New Peak

Blue Shield membership and benefit payments both reached record highs during 1965, while operating expenses fell to a new low, according to the 1965-66 Annual Report of the National Association of Blue Shield Plans.

Membership of the 85 Blue Shield Plans in the United States, Puerto Rico, Canada, and Jamaica increased 1,676,519 during 1965 to a record 57,933,295.

A record $1,354,962,286 in benefits was paid on behalf of Blue Shield subscribers during the year, up $133,105,819 over 1964.

Operating expenses during 1965 fell .3 per cent to an all-time low of 8.4 per cent.

Benefits paid out during the year amounted to over 90 per cent of subscription income. Subscription income in 1965 increased more than $145 million over 1964 to a record $1,503,635,279.

The 2.77 per cent enrollment increase during the year brought Blue Shield coverage in the United States to 27.3 per cent of the population.

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A complete social, sports and entertainment program for you and yours . . . in this World Apart. We warmly invite your inquiry for complete details.

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NED TANNER — Conference Consultant

What Can't Periodic Examination Do?

The University of Pennsylvania's School of Medicine, now in the process of surveying the entire area of the physical examination, with the support of the U. S. Public Health Service, said in a preliminary report that some usually fatal diseases are still extremely difficult to diagnose at an early stage.

The study concentrated on 350 adult males who had undergone periodic examinations at indefinite intervals, and yet subsequently died.

The University researchers found that the fatal illness was detected in only 51 per cent of the cases during the final examination before death occurred. A breakdown of the findings presents a more encouraging picture for the health examination. For example, of those persons who died from vascular disease, the cause had been discovered in 67 per cent of the cases at the last examination; and of the cases who died from valvular heart disease and other non-coronary heart conditions, the cause had been noted in 88 per cent of the cases.

Detection in the cause of death for coronary heart diseases —58%—and cancer—43%—were not as successful.

The Pennsylvania researchers said, "This does not negate the method. It points up the necessity for greater efforts toward improvement and changes in our diagnostic procedures in order to increase further the benefit to be derived from such examination."

ATTENTION DELEGATES:
MSMS HOUSE OF DELEGATES
SEPTEMBER 25-26-27
PANTLIND HOTEL, GRAND RAPIDS

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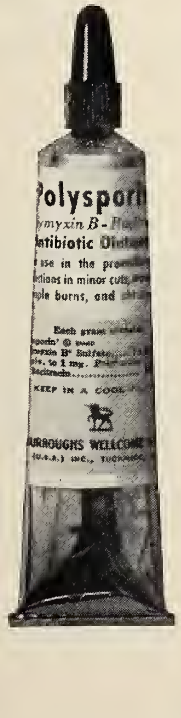
in treating topical infections, no need to sensitize the patient



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POLYMYXIN B-BACITRACIN
ANTIBIOTIC OINTMENT

broad-spectrum antibiotic therapy with minimum risk of sensitization

Caution: As with other antibiotic products, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **Contraindication:** This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.
Supplied: In ½ oz. and 1 oz. tubes
Complete literature available on request from Professional Services Dept. PML.

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Sustained circulatory, respirato and cerebral stimulation for t

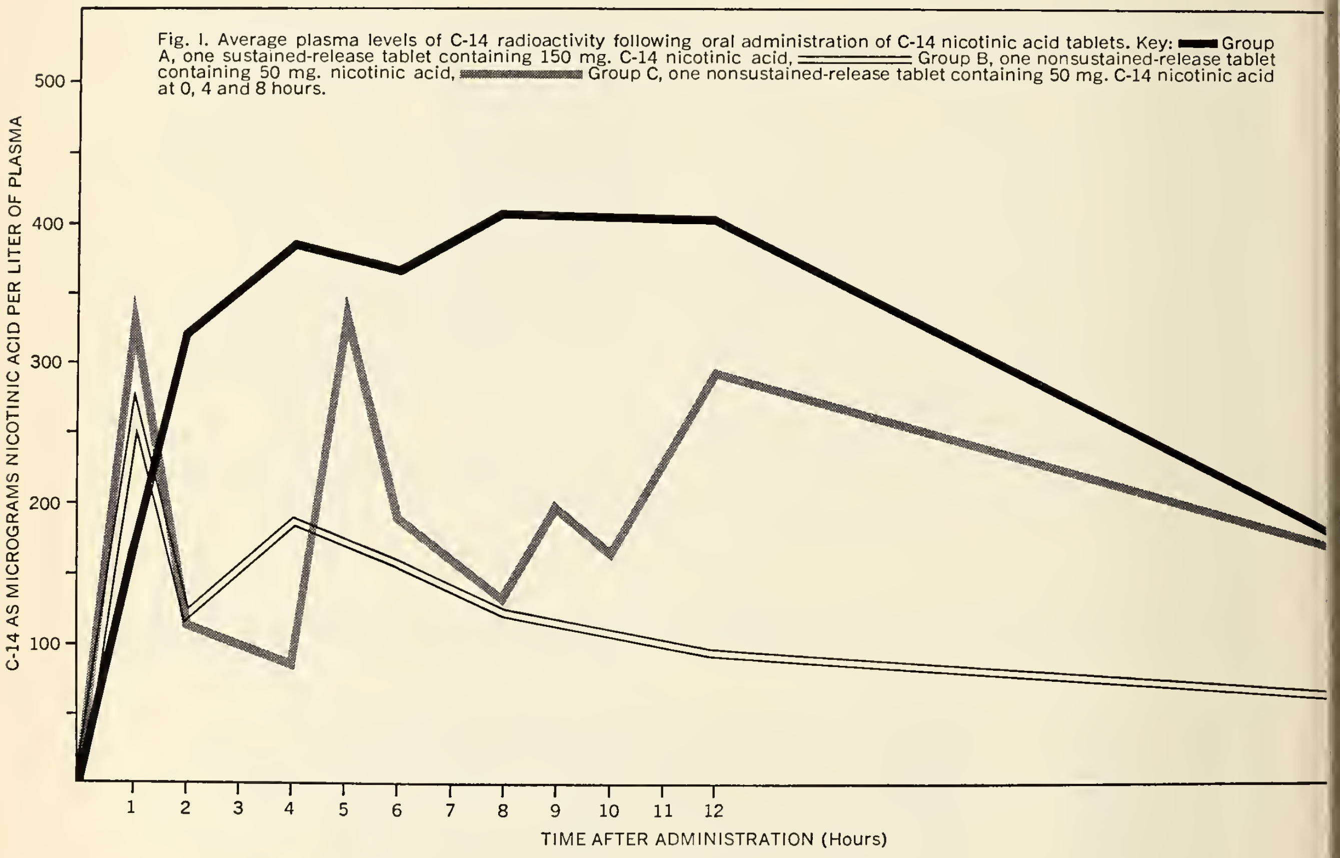

Fig. I. Average plasma levels of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

(fewer absent doses by absent-minded patients)

Human volunteer subjects were administered Geroniazol TT tablets with the nicotinic acid component made radioactive with C-14. Plasma and urine samples were analyzed. (See Figures I and II) The radioactive tracer study substantiated the previous clinical evidence that the release of nicotinic acid from the Geroniazol TT tablet produced a gradual rise in plasma levels to a plateau for a total of 12 hours and more.

Such proven sustained activity makes the management of geriatric patients much easier by minimizing the possibility of neglected doses through absent-mindedness or senile confusion. Therapy *can* be co tinuous on a daily dose of only one Geroniazol TT tal let every 12 hours.

The gradual release of nicotinic acid in Geroniaz TT will provide the well-known peripheral vasodilat tion needed in patients with deficient circulation ar with a minimum amount (if any) of "flushing." Als cerebrovascular circulation is complemented by pe tylenetetrazol, long-established as a cerebral and re piratory stimulant.

Geroniazol TT improves the typical, unfortunat signs of senile confusion. Patients become more aler

ged and debilitated

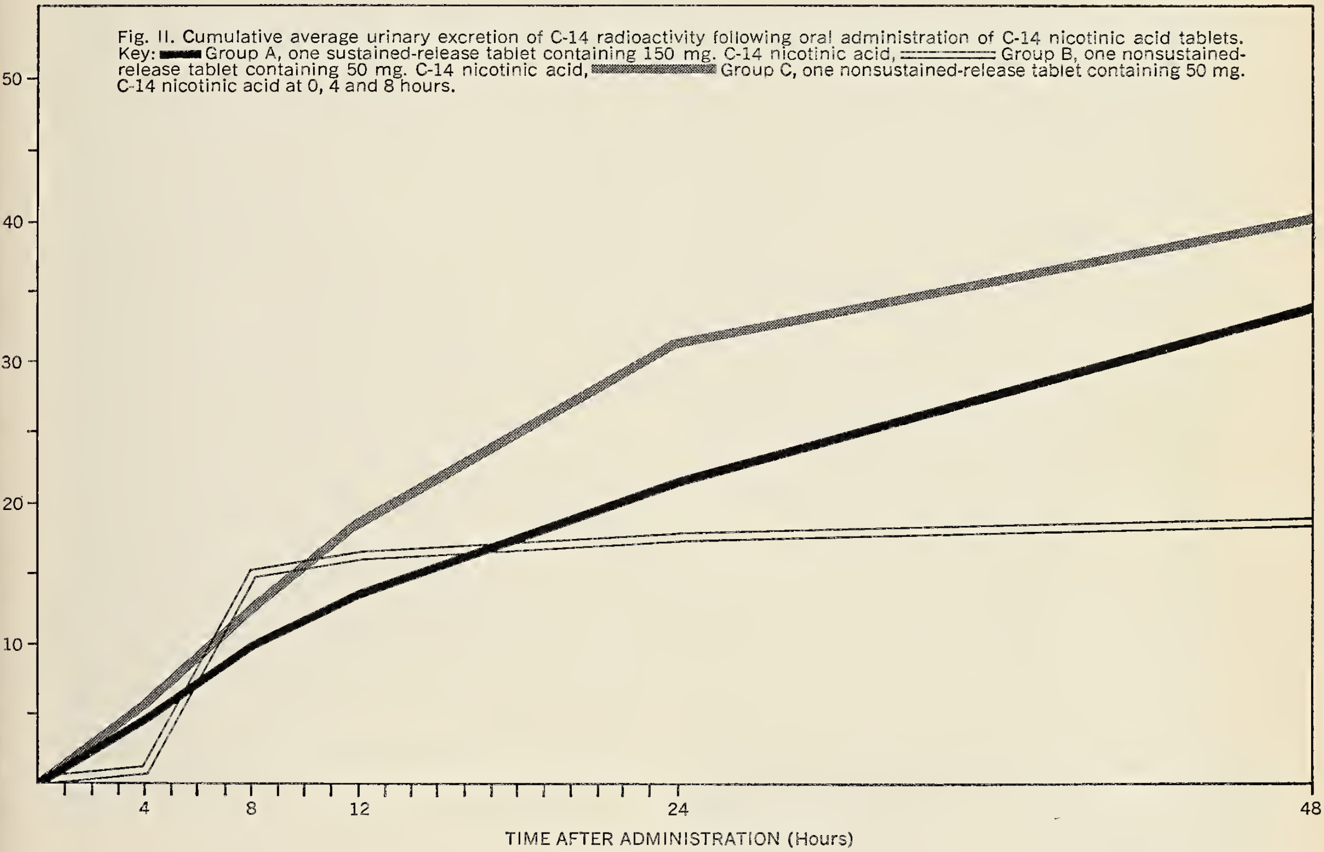

Fig. II. Cumulative average urinary excretion of C-14 radioactivity following oral administration of C-14 nicotinic acid tablets. Key: ▬ Group A, one sustained-release tablet containing 150 mg. C-14 nicotinic acid, ═ Group B, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid, ▨ Group C, one nonsustained-release tablet containing 50 mg. C-14 nicotinic acid at 0, 4 and 8 hours.

ess confused and moody. Personal care, memory, motional stability, social attention improve. Fatigue, pathy and irritability are reduced.

A prescription for 100 tablets of Geroniazol TT will ermit your patients to enjoy the benefits of time-rolonged nicotinic acid/pentylenetetrazol therapy, t an economical price. Dosage is only one tablet every 2 hours.

ontraindications: There are no known contraindications.

recautions: Exercise caution when treating patients ith a low convulsive threshold.

Side Effects: Side effects are rarely encountered, however due to the vasodilatation effect of nicotinic acid, transitory mild nausea, flushing, tingling and pruritus are possible.

Dosage: One tablet every 12 hours.

Supplied: Prescribe bottles of 100 tablets, to take advantage of recent price reduction.

References: 1. Report by Nuclear Science & Engineering Corp., Pittsburgh, Pa., in files of Philips Roxane Laboratories. 2. Connolly, R.: W. Virginia Med. J. *56*:263 (Aug.) 1960. 3. Curran, T. R., and Phelps, D. K.: Am. Pract. & Digest Treat. *11*:617 (July) 1960.

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nicotinic acid 150 mg., pentylenetetrazol 300 mg.
Tempotrol® Time Controlled Tablet

AMA to Open with Medicine-Religion

A dramatic presentation of how the clergyman and the physician can work together to help a family face the problem of the terminal patient will be featured at a special program on medicine and religion at 8:15 p.m., Sunday, June 26, at the Palmer House Hotel, Chicago.

The presentation will be a part of the 115th annual convention of the AMA, June 26-30, in Chicago.

The program will be open to all physicians and clergymen and their wives, and to the public, said The Rev. Dr. Paul B. McCleave, director of the sponsoring unit, the Department of Medicine and Religion of the American Medical Association.

The presentation will be an original drama, "Truth is Like Yellow," written especially for the occasion. The drama will probe the emotional problems facing the family, the physician and the clergyman in the case of a terminally ill patient.

Following the presentation a panel of two ministers and two physicians will discuss the implications raised by the drama.

Z. E. Taheri, M.D., left, principal speaker, is shown at the Michigan State Medical Assistants' Society Educational Seminar at Bay City with Mrs. Juanita Ferman, MSMAS President, and Glenn Millard, M.D., Detroit, MSMAS Advisor. More than 150 attended the annual seminar held at Bay City. Doctor Taheri, of Bay City, delivered the L. Fernald Foster Lecture.

Infant Mortality Conclave in West

A National Conference on Infant Mortality will be sponsored by the American Medical Association's Committee on Maternal and Child Care. The Conference will be held on August 12-13, at the Fairmont Hotel in San Francisco.

An open invitation to attend is being extended to chairmen and members of all state and county Maternal and Child Care; Perinatal and Maternal Mortality Committees; State Health Department Directors of Maternal and Child Health; medical school faculty members in Departments of Obstetrics and Gynecology, Pediatrics, and Preventive Medicine.

Special workshops will be arranged to discuss the identification of high risks, organization and delivery of special care services, manpower utilization, continuity of reproductive care and problems of prematurity. Other subjects to be covered by special speakers will include perinatal mortality studies, obstetric and pediatric education programs, research questions, expectant parent and sex education, and population control.

AMA Sports-Medicine Conclave in November

The eighth National Conference on the Medical Aspects of Sports, sponsored by the American Medical Association under the auspices of its Committee on the Medical Aspects of Sports, will be held in Las Vegas, Nevada, at Caesar's Palace on November 27, 1966.

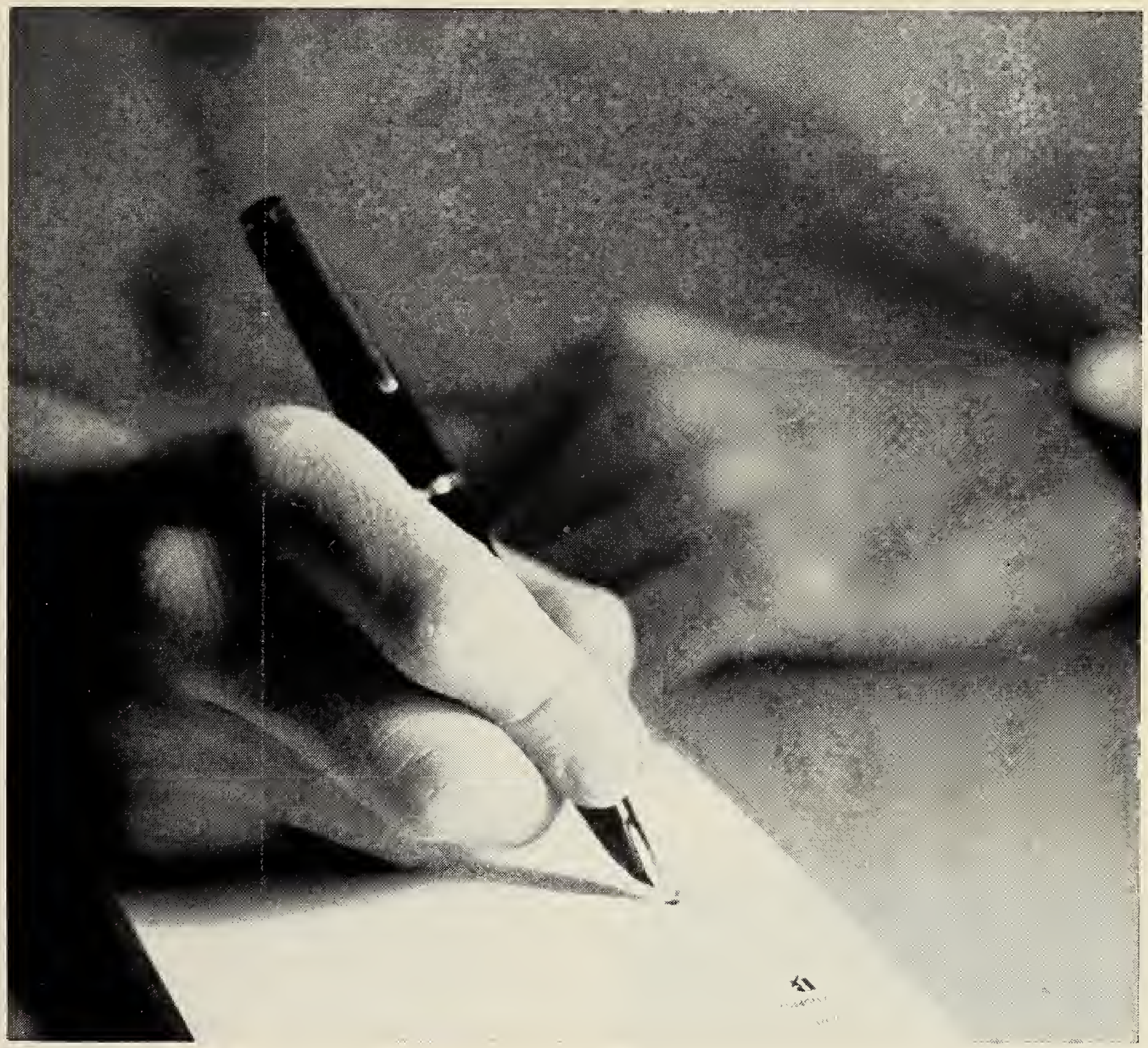
The conference is held annually in conjunction with and on the first day of the Clinical Convention of the American Medical Association.

The conference will relate to criteria for immediate management of knee injuries, resources for grass roots supervision of sports, medical preparations for international competitions, and the relationship of athletic fitness to physical fitness.

Those who would like to receive further information may write: Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn, Chicago, 60610.

DR. HEUSTIS HONORED

The Michigan Nursing Home Association convention in Detroit honored three persons for contributions to the nursing home profession in Michigan. The three honored were Victor Jonak, director of the nursing home licensure program of the State Department of Health, Albert G. Heustis, M.D., State Health Commissioner, and Congresswoman Martha Griffith.



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June 16, 17, 18—Upper Peninsula Medical Society Annual Meeting, Iron Mountain

June 22-25—Michigan Association for Retarded Children Conference, Northern Michigan University, Marquette

July 16-17—Upper Peninsula Seminar for Michigan State Medical Assistants, Sault Ste. Marie.

July 28-29—Coller-Penberthy-Thirlby Medical Conference, Traverse City Park Place Motor Inn

Sept. 12-16—Michigan Nurses Association, Conference for Operating Room Nurses, Kellogg Center, East Lansing

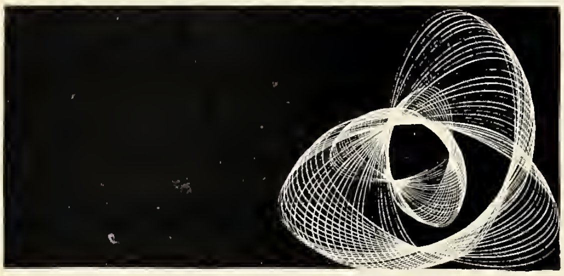
Sept. 25-27—Michigan State Medical Society House of Delegates, Pantlind Hotel, Grand Rapids

Sept. 27-28-29—Michigan State Medical Society Woman's Auxiliary, Pantlind Hotel, Grand Rapids

Sept. 28-30—Michigan State Medical Society Annual Scientific Session, Civic Center, Grand Rapids

Sept. 28-29—Michigan State Medical Assistants' Society Convention, Mr. President Motel, Grand Rapids

Oct. 16-22—Community Health Week



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Contraindications: In hyperexcitability and in agitated prepsychotic states. Previous allergic or idiosyncratic reactions.

Precautions: Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or are severely hypertensive.

Dextro-amphetamine sulfate: Use by unstable individuals may result in psychological dependence.

Meprobamate: Careful supervision of dose and amounts prescribed is advised; especially for patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g. alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence. Where excessive dosage has continued for weeks or months, reduce dosage gradually. Sudden withdrawal may precipitate recurrence of pre-existing symptoms such as anxiety, anorexia, or insomnia; or withdrawal reactions such as vomiting, ataxia, tremors, muscle twitching and, rarely, epileptiform seizures. Should meprobamate cause drowsiness or visual disturbances, reduce dose—operation of motor vehicles, machinery or other activity requiring alertness should be avoided. Effects of excessive alcohol consumption may be increased by meprobamate. Appropriate caution is recommended with patients prone to excessive drinking. In patients prone to both petit and grand mal epilepsy meprobamate may precipitate grand mal attacks. Prescribe cautiously and in small quantities to patients with suicidal tendencies.

Side Effects: Overstimulation of the central nervous system, jitteriness and insomnia or drowsiness.

Dextro-amphetamine sulfate: Insomnia, excitability, and increased motor activity are common and ordinarily mild side effects. Confusion, anxiety, aggressiveness, increased libido, and hallucinations have also been observed, especially in mentally ill patients. Rebound fatigue and depression may follow central stimulation. Other effects may include dry mouth, anorexia, nausea, vomiting, diarrhea, and increased cardiovascular reactivity.

Meprobamate: Drowsiness may occur and can be associated with ataxia, the symptom can usually be controlled by decreasing the dose, or by concomitant administration of central stimulants. Allergic or idiosyncratic reactions: maculopapular rash, acute nonthrombocytopenic purpura with petechiae, ecchymoses, peripheral edema and fever, transient leukopenia. A case of fatal bullous dermatitis, following administration of meprobamate and prednisolone, has been reported. Hypersensitivity has produced fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anuria, stomatitis, proctitis (1 case), anaphylaxis, agranulocytosis and thrombocytopenic purpura, and a fatal instance of aplastic anemia, but only when other drugs known to elicit these conditions were given concomitantly. Fast EEG activity, usually after excessive dosage. Impairment of visual accommodation. Massive overdosage may produce drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor, and respiratory collapse.

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MSMS Insert In AMA Booklet Gives State Info

The Michigan State Medical Society long has had a reputation of being a leader—and again, MSMS has scored another "first."

For many years, MSMS has published and distributed a handsome booklet about career opportunities in the health fields. School officials, librarians, et al, have been high in their praise.

When it became time again to update the information and reprint it, MSMS learned that the AMA was ready to print a pocketbook, "Horizons Unlimited."

Since there was no need to duplicate the effort and the cost, MSMS sought to tie in with the fine AMA book. Arrangements were made within several days to provide copy to the AMA for an eight-page insert which would provide Michigan information for interested Michigan students, counselors, libraries, etc.

The medical society purchased 10,000 of the booklets and the Michigan Health Council, another 5,000. No other state society did this with its own state insert.

The insert, printed on stiff yellow paper and placed in the middle of the AMA book, discusses the "Opportunities for Education and Training in the Health Field in Michigan." A total of 51 different health careers, which can be pursued in Michigan, are listed along with the 116 Michigan colleges and institutions that offer such training.

In part, the insert sets the stage in this manner:

"Whether you are a youth or an adult, uncounted opportunities exist in Michigan for well-paid employment and fruitful service in the health field.

"The doctors of medicine and the many statewide organizations interested in health are distributing this book as a means of encouraging young people—and adults, too—to consider the rewards that come daily to all those serving in the health field in this state.

"Michigan has long been a leader in health care, training, facilities and research. Comprehensive health care and the pursuit of excellence are sought continuously here by the professional societies in the health field, the voluntary health agencies, the hospitals, the colleges and universities."

Copies of the booklet were mailed to the 116 universities, colleges, community colleges, hospitals and other training institutions.

MSMS hopes now that the yellow pages can be reprinted in large quantities for broadside distribution to students, for use at career conferences, etc.

The MSMS Public Relations Committee has directed this project. Brock E. Brush, M.D., Detroit, Chairman, reports that systematic distribution is being made to high school libraries and counselors, junior high school libraries and counselors, college libraries, community public libraries, youth-serving organizations, medical auxiliary career committees, etc.

The supply is not sufficient to send one to each MSMS member; but a copy can be sent to the physician who is keenly interested for individual use in career counseling or in public speaking.

Following are excerpts from some of the letters

The new AMA career guidebook with the Michigan insert carries information about the many health-related occupations, including microbiologists and bacteriologists.

Thanks to Dexamyl®

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she can say "No thank you" to the crêpes suzette.

'Dexamyl' does more than most anorectics. Because it curbs appetite *and* lifts mood, 'Dexamyl' can encourage the discouraged dieter to stay on her diet.

The mood lift with 'Dexamyl' can make the difference between the success or failure of her diet plan.

Formulas: Each 'Dexamyl' Spansule® Capsule (brand of sustained release capsule) No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid [Warning, may be habit forming]. Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital [Warning, may be habit forming].

Principal cautions and side effects: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Insomnia, excitability and increased motor activity are infrequent and ordinarily mild.

Before prescribing, see SK&F product Prescribing Information.

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from educators who have evaluated the AMA booklet with our Michigan insert:

The "Horizons Unlimited" is an excellent booklet and I know it is much appreciated by all interested persons.

—Ben Duguid
Assistant to the President
Sienna Heights College

* * *

I believe the booklet "Horizons Unlimited" will be useful to counselors and students.

The descriptions of professional and practical nursing are good. This portion should be widely distributed to students and parents as they do not seem to understand the differences which are here presented in another manner.

—Dolores Keyser, *Chairman*
Nursing Department
Flint Community College

* * *

The writer thinks the book itself is an excellent idea and an invaluable aid in the hands of counselors at school.

—B. D. Dann, *Director*
Hackley Hospital
Muskegon

* * *

"Horizons Unlimited" is an excellent document—well-written and comprehensive.

Recommend that Junior High principals and counselors be addressees for this document. More and more junior high (11-13) youngsters are thinking about careers.

—Harold E. Sponberg,
President
Eastern Michigan University

* * *

We want to thank you for including our institution in the listing in "Horizons Unlimited."

I feel it is a fine idea and the printing should be distributed to all high schools, as this type of information is vital to people in guidance.

—Robert Vratanina, *Registrar*
North Central Michigan College
Petoskey

* * *

This seems to be a very fine book and one that fills a need. The many pictures makes it particularly attractive.

—(Mrs.) Margaret Crager, R.N.
Department Head
Detroit Practical Nursing Center
Detroit Public Schools

I am impressed with "Horizons Unlimited." I am sure it will be helpful in recruiting more people into the health fields.

—Lucy Mayer, R.N., *Director*
Practical Nurse Program
Lake Michigan College
Benton Harbor

* * *

Distribution of the AMA booklet, if possible, should include both junior and senior high schools in sufficient quantity to permit take-home reference from libraries or counselors' offices.

—Donald H. Carros
Assistant Administrator
Pontiac General Hospital

* * *

Thank you for the handbook on career opportunities in medicine and allied fields, "Horizons Unlimited." We are indebted to the American Medical Association for the factual compilation of the exhaustive research necessitated for production of the handbook, specifically to the Michigan Medical Society for the insert citing our contribution.

—Phyllis Lyons, R.N.
Practical Nurse Education Center
Gratiot Community Hospital
Alma

* * *

"Horizons Unlimited" seems to be a readable, val-

The Michigan insert in the new AMA booklet tells about 51 health careers that may be pursued at 110 Michigan colleges and hospitals. For example, the insert indicates that for veterinary medicine, the student may attend Michigan State University.

A.H.C.P.
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A Service For You And Your Patients

And this service begins by informing your patients about the American Health Credit Card, which permits them to pay you immediately for the health and medical services you perform.

That's the job of these American Health Credit Plan brochures contained in this attractive office and waiting room dispenser. You should have one by now, but if you don't and would like to receive the full story on how A.H.C.P. benefits you, send a note to:

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There's reassuring protection and skin comfort for those outdoor workers who use RVP-Elder. Swimmers, golfers and others engaged in outdoor activities can have the same skin protection.

A razor-thin layer of only 10 microns adheres tenaciously to the skin for hours, yet washes off easily with soap and water. Virtually invisible, RVP-Elder is odorless, non-staining, and perspiration and water resistant, even while swimming. No sensitivity has been encountered.

Supplied in 2 oz. and 16 oz.

Write for clinical trial package and absorption spectrum

References: (1) Schoch, A. G.: Current News in Dermatology, August, 1963; (2) Jillson, O. F., and Baughman, R. D.: Arch. Dermat. 88:409, 1963; (3) Cole, H. N., et al.: J.A.M.A. 130: 1, 1946; (4) MacEachern, W. N., and Jillson, O. F.: Arch. Dermat. 89: 147, 1964.

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CAREER BOOKLET/Continued

uable resource for high school students choosing careers.

The illustrations and content are excellent.

—Helen Friedrich, R.N.
School of Nursing
Butterfield Hospital
Grand Rapids

* * *

I think the booklet would be an excellent source of information to students seeking career information.

I hope it will be placed in every junior and senior high school library around the state.

—Mrs. Irene Smith, R.N.
Mercy School of Practical Nursing
Cadillac

* * *

We were glad to receive "Horizons Unlimited." We feel it will be a very helpful book to have in giving correct information to people interested in employment in the health field.

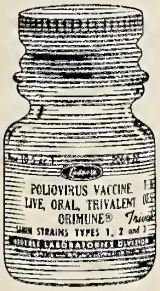
—Rosalyn Ghysels, R.N., *Director*
Division of Practical Nursing
Grand Rapids Junior College

* * *

We have had many High School Health Career

Every year, many Michigan girls enter nursing. The AMA career booklet with the Michigan insert points out that there are 28 colleges and hospitals that offer training in professional nursing, and 23 that offer training in practical nursing.

Doctor...two important Lederle products for routine office procedures



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Fast, simple administration—and economy for the patient—make the new 0.5 cc single-dose vial of ORIMUNE Trivalent ideal for private practice. (Packaged 5 to a box with 5 sterilized disposable droppers for your convenience).
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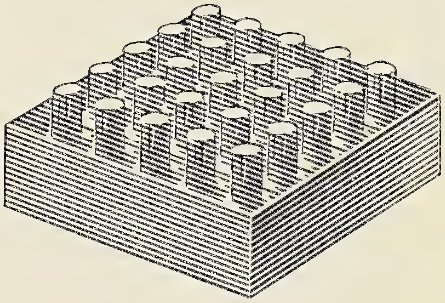
Effectiveness—may be expected to confer active immunity against all three types of poliovirus infection in at least ninety percent of susceptibles only if given at full dosage, as directed. No characteristic side effects have been reported. There are, however, certain contraindications. These are, broadly: acute illness, conditions which may adversely affect immune response, and advanced debilitated states. In these, vaccination should be postponed until after recovery.
In infants vaccination should not be commenced before the sixth week of life. Do not give to patients with viral disease, or if there is persistent diarrhea or vomiting. ORIMUNE and live virus measles vaccine should be given separately.
Dosage—initial immunization: two doses each given orally at least 8 weeks apart. (Give a third dose to infants at 10-12 months). Booster immunization: one dose, given orally. See package literature for full directions.



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Comparable in accuracy and reliability to older standard intradermal tests*, but faster and easier to use. Since TINE TEST is relatively painless it should receive greater patient acceptance. Results are read at 48-72 hours. The self-contained, completely disposable unit requires no refrigeration and is stable for two years.
Side effects are possible but rare: vesiculation, ulceration or necrosis at test site. Contraindications, none; but use with caution in active tuberculosis. Available in boxes of 5 (new individually-capped unit); cartons of 25.

*Rosenthal, S. R., Nikurs, L., Yordy, E., and Williams, W.: Scientific Exhibit Presented at the Annual Meeting of the National Tuberculosis Association, Chicago, Illinois, May 30-June 2, 1965.

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CAREER BOOKLET/Continued

Days here at St. Mary's and have had high school students tell us that they have difficulty getting correct information from their high school counselors about health careers. For this reason "Horizons Unlimited" should be a great help both to high school counselors and students. Also, the local medical society auxiliaries could certainly use them to advantage with their health career clubs.

—Mrs. Virginia Carter
Director of Public Relations
St. Mary's Hospital
Saginaw

* * *

This information should be very helpful to all concerned with recruiting students into educational programs for preparation for the health occupations.

—Harriett H. Sattig, R.N.
Director of Nursing Education
Schoolcraft College
Livonia

* * *

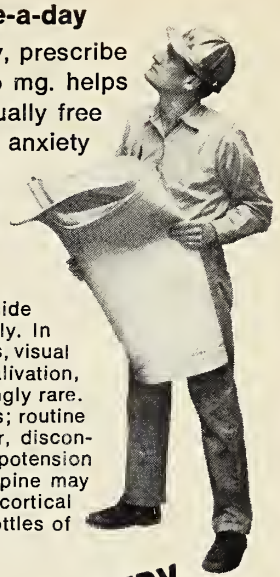
The booklet "Horizons Unlimited" is a fine little book which gives essential information and, equally important, the names of societies where additional information can be obtained.

I would suggest that the booklets be available to all high school counselors, public libraries, hospital and college libraries and doctors' offices.

—Sister Mary Gabrielle, R.S.M.
Acting Chairman
Department of Nursing
Mercy College of Detroit

Spotlight on MSMS

The AMA has sent a copy of their new career booklet to each of the state medical societies and it has praised the efforts of MSMS. Walter S. Wiggins, M.D., Secretary of the AMA Council on Medical Education, wrote in part: "If you wish to consider a much wider distribution of the book through your medical societies, women's auxiliaries or coordinated groups concerned with promoting health careers, you may be interested in developing a special, localized insert as the Michigan State Medical Society and the Michigan Health Council has done. The "Michigan" version, with an eight-page insert, lists all the Michigan schools and hospitals offering training for individual health careers."



Blueprint for dealing with tension due to stress—Prolixin—once-a-day

For the patient who must be on the job mentally as well as physically, prescribe Prolixin. The prolonged tranquilizing action of as little as one or two mg. helps him cope with tension all day long. Markedly low in toxicity and virtually free from usual sedative effects, Prolixin is effective in controlling both anxiety associated with somatic disorders and anxiety due to environmental or emotional stress. Patient acceptance is good — because Prolixin is low in cost, low in dosage and low in sedative activity. Prescribe Prolixin.

Side Effects, Precautions, Contraindications: As used for anxiety and tension, side effects are unlikely. Reversible extrapyramidal reactions may develop occasionally. In higher doses for psychotic disorders, patients may experience excessive drowsiness, visual blurring, dizziness, insomnia (rare), allergic skin reactions, nausea, anorexia, salivation, edema, perspiration, dry mouth, polyuria, hypotension. Jaundice has been exceedingly rare. Photosensitivity has not been reported. Blood dyscrasias occur with phenothiazines; routine blood counts are recommended. If symptoms of upper respiratory infection occur, discontinue the drug and institute appropriate treatment. Do not use epinephrine for hypotension which may appear in patients on large doses undergoing surgery. Effects of atropine may be potentiated. Do not use with high doses of hypnotics or in patients with subcortical brain damage. Use cautiously in convulsive disorders. **Available:** 1 mg. tablets. Bottles of 50 and 500. For full information, see Product Brief.

WHEN TRANQUILIZATION WITHOUT SEDATION IS DESIRABLE, TRY

PROLIXIN®

SQUIBB FLUPHENAZINE HYDROCHLORIDE

THE SQUIBB TRANQUILIZER

SQUIBB Squibb Quality – the Priceless Ingredient

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Second row, left to right—D. Roemer Smith, M.D.; John J. Coury, M.D.; Harvey C. Hansen, M.D.; John R. Pedden, M.D.; Louis F. Hayes, M.D.; Edward H. Rodda, M.D.; Brooker L. Masters, M.D.

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Not pictured—Robert V. Daugharty, M.D.; William A. Hyland, M.D.; Luther R. Leader, M.D.; Oliver B. McGillicuddy, M.D.; Edward J. Tallant, M.D.; Milton R. Weed, M.D.

For prompt, emphatic diuresis

aquaTAG®
(BENZTHIAZIDE)

NEW FROM TUTAG for prompt, comfortable diuretic action with a balanced excretion of sodium chloride and a lower potassium loss under normal dosage and diet regimen

DIURETIC ACTION: Clinically, the oral administration of AQUATAG (benzthiazide) results in diuretic activity within two hours with maximal natriuretic, chloruretic, and diuretic effects occurring during the fourth, fifth and sixth hours. Maintenance of response continues for approximately 12 to 18 hours. Acidosis is an unlikely complication since therapeutic doses of AQUATAG (benzthiazide) do not appreciably increase bicarbonate excretion. Edematous patients receiving 50 mg. of AQUATAG (benzthiazide) daily for five days developed a maximal increase in the rate of sodium excretion on the first day, and maintained this high rate until depletion of excessive body stores of sodium.

In congestive heart-failure patients, AQUATAG (benzthiazide) produced the same weight loss, during a 48-hour treatment period as did a maximally effective dose of hydrochlorothiazide.

DOSAGE: Diuresis, initially 50 to 200 mg.; maintenance 25 to 150 mg., daily. Hypertension 50 to 100 mg. initially, adjusted to 50 mg. t.i.d. or downward to minimal effective dosage level.

PRECAUTIONS AND SIDE EFFECTS: Electrolyte imbalance with hypokalemia, hypochloremic alkalosis and hyponatremia may occur. Other reactions may include blood dyscrasias, hyperuricemia and gout, nausea, jaundice, anorexia, vomiting, diarrhea, dizziness, paresthesia, photosensitivity and headache. Insulin requirements may be altered in diabetes.

WARNINGS: Dosage of coadministered antihypertensive agents should be reduced by at least 50%. Use with caution in edema due to renal disease; advanced hepatic disease or suspected presence of electrolyte imbalance. Stenosis or ulcer of small intestine have been reported with coated potassium formulas and should be administered only when indicated. Until further clinical experience is obtained, the use of the drug in pregnant patients should be carefully weighed against possible hazards to the fetus.

CONTRAINDICATIONS: AQUATAG (benzthiazide) is contraindicated in progressive renal disease or disfunction including increasing oliguria and azotemia. Continued administration of this drug is contraindicated in patients who show no response to its diuretic or antihypertensive properties.

Before prescribing or administering, read the package insert or file card available on request.

Available as 25 or 50 mg. scored tablets.

Request clinical samples and literature on your letterhead.

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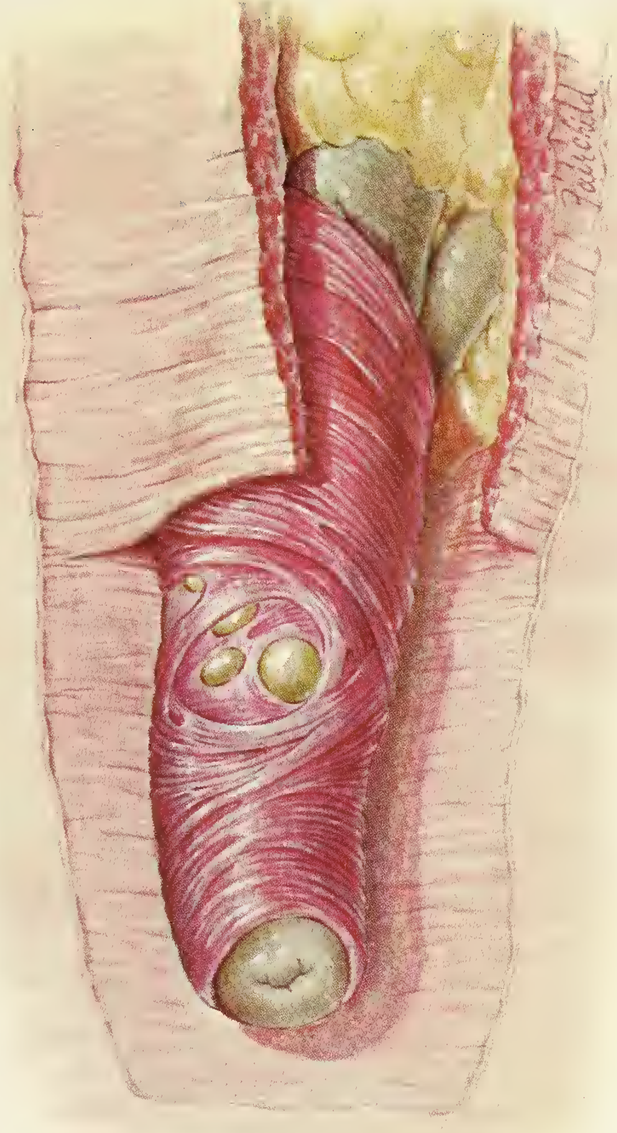
illustration after Boyden



HOW IMPORTANT IS THIS

IN YOUR DIAGNOSES OF SMOOTH MUSCLE SPASM?

6 Philips Roxane, Inc.

PERHAPS VERY IMPORTANT

The sphincter of Oddi is made up primarily of smooth muscle fibers. It permits the gall bladder to fill, regulates the flow of bile and pancreatic enzymes and in dysfunction is a primary cause of Biliary Dyskinesia. The sphincter of Oddi is but one of five major foci of smooth muscle spasm where SPACOLIN® (Alverine citrate) acts directly with rapid onset and long duration. No neurotropic side effects because Spacolin is a musculotropic counter-spasmodic unrelated to atropine or atropine-like drugs. Spacolin is not contraindicated in prostatic hypertrophy.

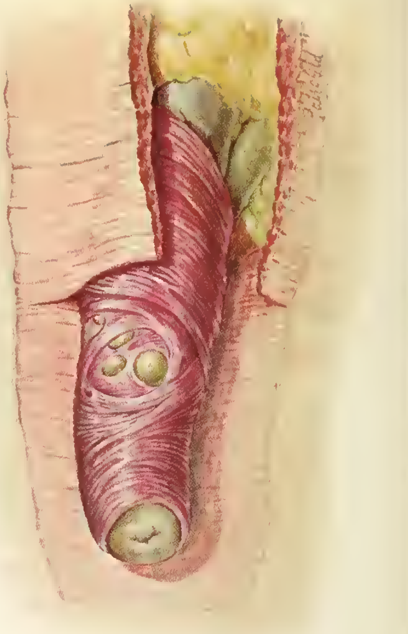
SPACOLIN® **(Alverine citrate)**

Each tablet contains: Alverine citrate .... 120 mg.

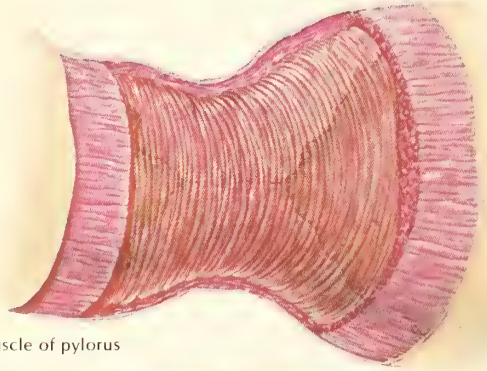
INDICATIONS: Smooth muscle spasmolytic for use in spastic colon, spastic conditions of the gastrointestinal tract, biliary dyskinesia, cholecystitis, spasm associated with peptic ulcer,* achalasia, pylorospasm, spasm attendant to diarrhea, spastic conditions of the genitourinary tract attributable to inflammation and calculi, certain primary dysmenorrheas and as an aid in cystoscopic, esophagoscopic and gastroscopic examinations. DOSAGE: One tablet after meals 1 to 3 times daily at discretion of physician. When treating spasm associated with peptic ulcer, achalasia or pylorospasm, administer tablets ½ hour before meals. In dysmenorrhea, one tablet 3 times daily starting at onset of discomfort. PRECAUTION: Caution is recommended when using in hypotensive patients. SIDE EFFECTS: In common with other smooth muscle depressants, Spacolin temporarily lowers blood pressure.

*Antacid and dietary measures are of primary importance in ulcer treatment and should not be neglected.

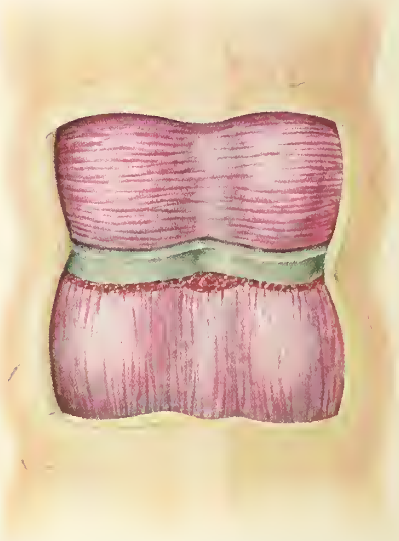
PHILIPS ROXANE LABORATORIES Division of Philips Roxane, Inc.,
Columbus, Ohio



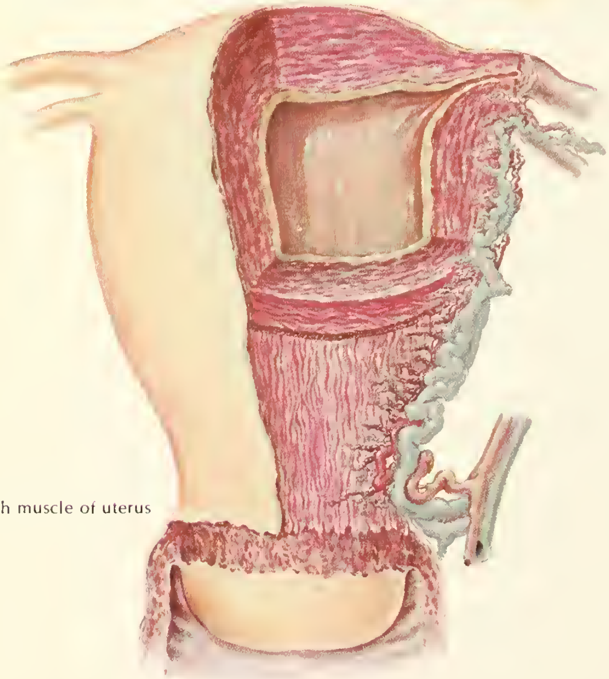
smooth muscle sphincter of Oddi



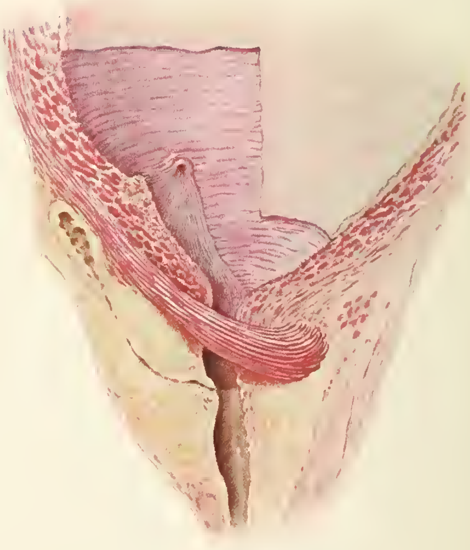
smooth muscle of pylorus



smooth muscle of colon



smooth muscle of uterus



smooth muscle of urinary bladder

From the Mailbag

Everyone here enjoyed the Healthmobile exhibit, ncluding the historical and developmental elements. tudents expressed considerable interest in career in-ormation. This seems like an attractive way to bring nformation to a broad selection of the public.

Robert E. Rice, M.D., President
Ionia-Montcalm County Medical Society

ear Editor:

Year after year the pages of the Journal of the ISMS have presented Mr. Wilbur Cohen as the ated and feared antagonist of physicians.

Now, in the April, 1966, issue of Michigan Medi-INE, Robert J. Mason, M.D., Vice-Chairman, MSMS ouncil, resumes the personal attack. He states: "Mr. ohen, Under Secretary of HEW, is the chief archi-ect of current social legislation. . . . He is the chief trategist in concocting all major Medicare legisla-ion."

Now the architects of Medicare and other Social ecurity legislation are the Congress and the Presi-ent of the United States. Mr. Cohen is nothing but skilled draftsman filling in the architects' plans. f not he, there would be others, but Medicare would still be the law of the land. He merits neither the credit nor the blame for Medicare.

Let's assign responsibility where it belongs.

Sincerely,
William A. Henkin, M.D.
Southfield

The Michigan Dietetic Association has received your request regarding dietetic careers pamphlets. We have decided to distribute 500 dietetic career pamphlets to you monthly.

We feel the "Healthmobile" is a very worthwhile project; and, we are delighted that we can be of service to you.

We wish you much success in this wonderful venture.

Sincerely yours,
Marilyn Eaddy
Michigan Dietetic Association
Career Guidance Chairman

Fundamental causes of auto accidents will be explored by the new auto safety institute at the University of Michigan. The auto industry contributed $10 million to the U-M in January.

TO ALL MY PATIENTS

I invite you to discuss frankly with me any questions regarding my services or my fees. The best medical service is based on a friendly, mutual understanding between doctor and patient.

This attractive office plaque, available from the American Medical Association, will encourage better understanding between you and your patients. Suitable for wall or desk display, the plaque measures 6" x 10½". The lettering is white on a dark brown background and the frame is durable beige plastic. The plaque is designed to blend well with any office decor. Cost of the plaque is $1.25, postpaid. To place your order, write to the Order Department, American Medical Association. Make check payable to the AMA.

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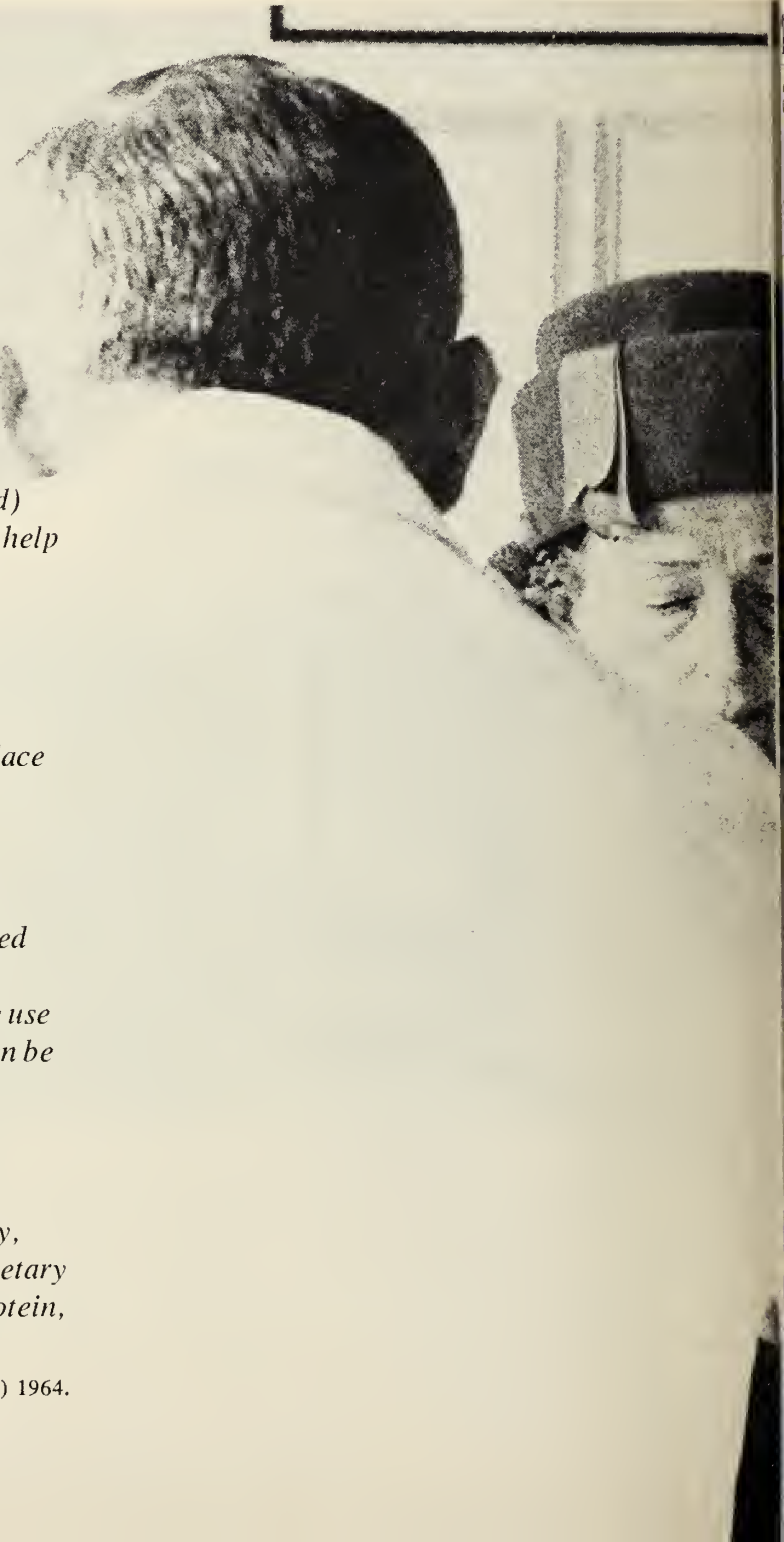
The Mediatric Age:

There is a growing senescent body of people on their way to malignant inactivity, who sorely need your interest and direction to help them back to a more activ and useful life. There are medicines too, designed to help One such has proved useful in clinical practice.



"A steroid-nutritional compound (Mediatric) was used in 100 patients to relieve some of the symptoms caused by degenerative changes of aging . . . This therapy resulted in improvement of 75 per cent of the patients . . ."

McNeill, A. J.: Clin. Med. *8*:518 (Mar.) 1961.

"Mediatric (steroid-nutritional compound) capsules, one a day, seem to give definite help to debilitated patients."

Arnold, E. T., Jr.: Geriatrics *12*:612 (Oct.) 1957.

"Nutritional and hormone bolstering of function in the aged may have a useful place in geriatrics."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"In diets which for any reason are restricted in calories, enough of these substances (B vitamins) may not be supplied . . . The use of B and C vitamin supplements may then be justified and indeed may be necessary."

Morgan, A. F.: Gerontologist *2*:77 (June) 1962.

"Intensive nutritional therapy is necessary, especially in elderly people, to correct dietary deficiencies created by large losses of protein, vitamins and other nutrients."

Riccitelli, M. L.: J. Am. Geriatrics Soc. *12*:489 (May) 1964.

Mediatric®

Designed for the "metabolically spent"

Nutritional reinforcement for those who can't—or won't—eat properly...balanced amounts of estrogen and androgen to counteract declining gonadal hormone secretion and its sequelae of premature degenerative changes...mild antidepressant for a gentle "mood" uplift...

The estrogen component in MEDIATRIC is PREMARIN® (conjugated estrogens—equine), the natural estrogen most widely prescribed for its superior physiologic and metabolic benefits.

MEDIATRIC also provides *nutritional reinforcement—blood-building factors and vitamin supplementation*. It contributes a *gentle "mood" uplift* through methamphetamine HCl.

Three different dosage forms—Liquid, Tablets, and Capsules—offer convenience and variety.

MEDIATRIC Liquid

Each 15 cc. (3 teaspoonfuls) contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Thiamine HCl	5.0 mg.
Cyanocobalamin	1.5 mcg.
Methamphetamine HCl	1.0 mg.

Contains 15% alcohol

MEDIATRIC Tablets and Capsules

Each MEDIATRIC Tablet or Capsule contains:

*Conjugated estrogens—equine (Premarin®)	0.25 mg.
Methyltestosterone	2.5 mg.
Ascorbic acid	100.0 mg.
Cyanocobalamin	2.5 mcg.
Intrinsic factor concentrate	8.0 mg.
Thiamine mononitrate	10.0 mg.
Riboflavin	5.0 mg.
Niacinamide	50.0 mg.
Pyridoxine HCl	3.0 mg.
Calc. pantothenate	20.0 mg.
Ferrous sulfate exsic.	30.0 mg.
Methamphetamine HCl	1.0 mg.

*Orally active, water-soluble conjugated estrogens derived from pregnant mares' urine and standardized in terms of the weight of active, water-soluble estrogen content.

MEDIATRIC helps keep the older patient alert and active; helps relieve general malaise, easy fatigability, vague pains in the bones and joints, loss of appetite, and lack of interest usually associated with declining gonadal hormone secretion.

CONTRAINDICATION: Carcinoma of the prostate, due to methyltestosterone component.

WARNING: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

SIDE EFFECTS: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

SUGGESTED DOSAGES: *Male and female:* 3 teaspoonfuls of Liquid, 1 Tablet, or 1 Capsule, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

SUPPLIED: No. 910 – MEDIATRIC Liquid, in bottles of 16 fluidounces and 1 gallon. No. 752 – MEDIATRIC Tablets, in bottles of 100 and 1,000. No. 252 – MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.

16 fl. oz.
No. 910
MEDIATRIC
LIQUID
Ayerst
Each 15 cc. (3 teaspoonfuls) contains:
Conjugated estrogens—equine (Premarin®) 0.25 mg.
Methyltestosterone 2.50 mg.
Thiamine HCl 5.00 mg.
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SHAKE WELL BEFORE USING
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MEDIATRIC
TABLETS
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Classified Ads

WANTED: Staff physician at the State Prison of Southern Michigan to work with four other physicians in the medical care of approximately 4,000 male felony offenders, the majority of whom are in maximum custody environment. Salary $17,455 to $21,380 depending on qualifications. Forty-hour week, paid insurance, vacation, sick leave, social security and retirement benefits. Write: Clifford S. Davis, Personnel Officer, Department of Corrections, 237 S. T. Mason Bldg., Lansing, Michigan 48926.

EASTERN WISCONSIN CLINIC in rapidly growing community of 40,000 desires board-eligible or certified physicians in pediatrics, obstetrics and gynecology, and internal medicine. Well-equipped clinic and excellent hospital facilities. Lake shore location offers ample recreational facilities. Attractive financial plan leading to early full partnership. Full expenses paid for applicants invited to interview. Call or write: F. L. Hildebrand, M.D., Riverside Clinic, Menasha, Wisconsin.

FOR RENT OR LEASE: Medical Suite in Highland Park, Michigan. Air conditioned private waiting room. Ideal for General Practice—General Surgery and Pediatrics. Phone. Townsend 8-8760.

PHYSICIAN POSITIONS available in the Medical/Surgical Service or ward areas of a progressing psychiatric hospital. Active teaching program. Salary up to $18,771 per annum, plus 6% increase in July. Contact: L. J. Marx, M.D., Clinical Director, Ypsilanti State Hospital, Ypsilanti, Michigan 48197.

MEDICAL TECHNOLOGISTS: ASCP certified or eligible, also vacancy in Cytology. Modern clinical laboratory. Excellent salary and benefits in a 360-bed general hospital with large expansion and building program for 1966. Apply: Edward W. Sparrow Hospital, Personnel Office, Lansing, Michigan.

RESIDENTS IN PATHOLOGY: Edward W. Sparrow Hospital, Lansing, Michigan: a 360-bed, general, community, non-profit hospital expanding to 440 beds in 1966. The only hospital affiliated with new developing Michigan State University School of Medicine. Approved four-year residency in clinical and surgical pathology. 195 autopsies, 7,500 surgicals and 200,000 clinical procedures per year. Well equipped laboratory, staffed with two full-time Board Certified PA-CP Pathologists and a Technical Director, Ph.D. in Biochemistry. Starting salary of $6,000 with yearly increases.

AGGRESSIVE SURGEON to head dynamic seven-man multi-specialty group with our ultra-modern clinic and hospital in Detroit suburb. Challenging scientific environment. Most rewarding financial arrangements. Write Box 18, 120 W. Saginaw Street, East Lansing, Michigan.

OB-GYN to join multi-specialty group. Growth area. Write Box 15, 120 W. Saginaw Street, East Lansing, Michigan.

INTERNIST wanted on a consultative basis. Fee for services. Write Box 16, 120 West Saginaw Street, East Lansing, Michigan.

WANTED PHYSICIAN interested in general practice with six-man group in suburbs of Detroit. Delicious salary and future partnership. Write Box 17, 120 West Saginaw Street, East Lansing, Michigan.

WANTED GENERAL PRACTITIONER OR INTERNIST: To join surgeon and general practitioner and substitute for third man leaving for post graduate training July 1, 1966. Located on St. Clair River in Southeast Michigan with excellent recreational facilities: boating, fishing, hunting and golfing. Night calls and long weekends off rotated among the men. Excellent income, salary open. Position temporary or permanent, dependent upon qualifications and desires. Reply St. Clair Clinic, 1605 Fred Moore Hwy., St. Clair, Michigan.

MEDICAL SUITES, specialist desired, Newbergh Heights Medical Village, immediate occupancy, heating, air conditioning, FM system, intercom phone system, leaded x-ray room, luxurious reception room. Seeing is believing. Call area code 313-PA 2-5130.

LAKE COTTAGE on beautiful Driggs Lake in Upper Peninsula. Strictly modern cottage, mahogany paneled, tiled floor throughout. Electric and gas lights. Automatic gas floor furnace. Sleeps seven. Eight acres white birch, pine, spruce, maple and beech trees. Excellent hunting and fishing. Many trout streams nearby. No public fishing site on lake. Complete privacy. Cottage three years old. Leased duck marsh. Completely furnished with all tools. $16,000. C. B. Washburne, Box 72, Seney, Michigan.

OFFICE SPACE available for 1 or 2 physicians in new Professional Building, now being completed. Excellent location, near downtown Lansing. Phone Lansing, Michigan, area code 517 IV 4-0329 or 372-2259.

MODERN OFFICE SUITE AVAILABLE for specialist or general practice in North Muskegon, Michigan. Will rent at $275.00 per month. Write Box 10, 120 W. Saginaw Street, East Lansing, Michigan.

MODERN MEDICAL BUILDIN FOR LEASE: Suitable for 3 or positions. Building has 2400 sq. ft divided into 19 rooms including waiting room, x-ray, drug, and lab rooms Rent is less than $.20 per sq. ft. pe month. Will be available July 1, 1966 Office is located at 2060 Alpine, N.W. Grand Rapids, Michigan. For furthe information, write Fairview Pharmacy 2062 Alpine N.W., Grand Rapids Michigan or call 616/363-6861.

WANTED: Locum tenens for the month of July, August, and as much o September as possible, or an associat to take the place of the one who i now specializing. This is a well established general practice in Souther Michigan, offices located in the hospital. Consider this an excellent opportunity for a young man. Contact B. H. Growt, M.D., Addison, Michigan.

AIR CONDITIONED office suite available for M.D. with full utilities paid Adequate parking, moderate rent some equipment available. Ideal location for General Practitioner or Pediatrician. Contact W. F. Adgate, D.D.S. 3526 W. Saginaw Street, Lansing Michigan.

MEDICAL DIRECTOR for Tri-County Health Department. Population 112,000, located in lower central Michigan requirements, M.D., M.P.H., salary range contingent on qualifications approximately $20,000. Direct inquiries to Charles A. Potter, Acting Director Branch-Hillsdale District Health Department, 35 South Sprague Street Coldwater, Michigan.

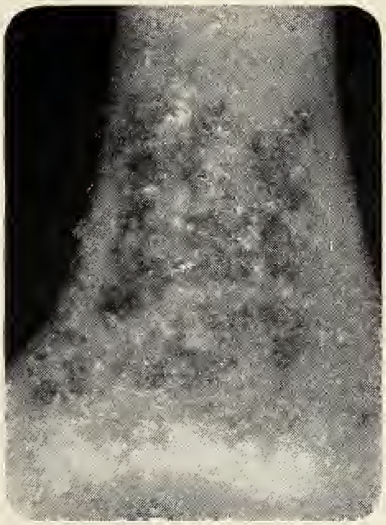
PSYCHIATRIST, full or part-time. Position in expanding mental hygiene clinic with modern day care center. In 890 bed General Medical Teaching Hospital. Salary up to $20,000 depending on qualifications. Excellent fringe benefits. Congenial staff. For specific details and application write: Chief of Staff. Veterans Administration Hospital, Dearborn, Michigan.

GENERAL PRACTICE: Office, equipment and going practice for sale because of illness. Located in the Flint area. Presently grossing in excess of $120,000 per year. Please write Box 19, 120 West Saginaw Street, East Lansing, Michigan.

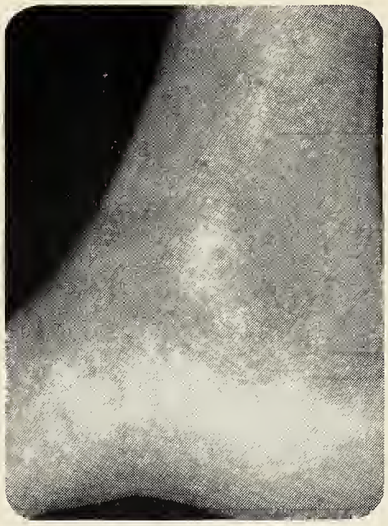
POSITION WANTED: General practitioner wants position in or near Flint, Michigan. 38 years of age with seven years experience in General Practice. Please write Box 20, 120 West Saginaw Street, East Lansing, Michigan.

PUBLIC HEALTH PHYSICIAN — to work in generalized community public health program in Lenawee County, population 80,000. Well established unit in growing community—within 35 miles of University Medical Center and School of Public Health, Ann Arbor, Michigan. Must be U. S. citizen, have Michigan License or eligibility for license. Tentative salary $22,000 with yearly increments. Apply to Lenawee County Health Department, 113 W. Front Street, Adrian, Michigan 49221.

eczema: scourge of childhood



R. R., Age 11—Before treatment—
atopic eczema of long standing



After treatment—with ARISTOCORT
Topical Ointment 0.1% for two weeks

ISTOCORT® Triamcinolone Acetonide Topicals have oved exceptionally effective in the control of various ms of childhood eczema: allergic, atopic, nummular, oriatic, and mycotic.

In most cases responsive to topical ARISTOCORT, e 0.1% concentration is sufficiently potent. The 0.5% ncentration provides enhanced topical activity for tients requiring additional potency for proper relief.

lministration and Dosage: Apply sparingly to the affected ea 3 or 4 times daily. Some cases of psoriasis may be more ectively treated if the 0.1% Cream or Ointment is applied der an occlusive dressing.

ntraindications: Tuberculosis of the skin, herpes simplex, icken pox and vaccinia.

ecautions and Side Effects: Do not use in the eyes or in ear (if drum is perforated). A few individuals react unvorably under certain conditions. If side effects are enuntered, the drug should be discontinued and appropriate measures taken. Use on infected areas should be attended with caution and observation, bearing in mind the potential spreading of infection and the advisability of discontinuing therapy and/or initiating antibacterial measures. Generalized dermatological conditions may require systemic corticosteroid therapy. Steroid therapy, although responsible for remissions of dermatoses, especially of allergic origin cannot be expected to prevent recurrence. The use over extensive body areas, with or without occlusive nonpermeable dressings, may result in systemic absorption. Appropriate precautions should be taken. When occlusive nonpermeable dressings are used, miliaria, folliculitis and pyodermas will sometimes develop. Localized atrophy and striae have been reported with the use of steroids by the occlusive technique. When occlusive nonpermeable dressings are used, the physician should be aware of the hazards of suffocation and flammability. The safety of use on pregnant patients has not been firmly established. Thus, do not use in large amounts or for long periods of time on pregnant patients.

Packages: Tubes of 5 Gm. and 15 Gm.; ½ lb. jar.

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ristocort® Topical Ointment 0.1% and Cream 0.1%, 0.5%
riamcinolone Acetonide
Also available in foam form and with neomycin.

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Community Health

As your president, it is my opportunity to attend many medical meetings in Michigan, and to represent you at such medical societies recently as Wisconsin, Minnesota, Ohio and Illinois.

In attending such meeting, I have heard many fine speakers on vital topics. And I have read many excellent reports that reach my desk. I was startled the other day to learn that:

84 per cent of the nation's population now live in 112 communities.

This growing trend presents many challenges to physicians and medical organizations.

We pride ourselves in the high standards of community health. But, as more and more people pack into some of our largest cities, we do face health hazards. Contributing to the situation are such problems as communicable diseases, waste disposal, housing and zoning, conflicting value systems, mental illness from tensions and frustrations, etc.

Physicians medical organizations, hospitals, etc., face the challenges of cooperation and coordination of health services. The problems of attaining and maintaining adequate community health programs and services are complex.

Your Michigan State Medical Society has launched a new service arm this year—that of Research and Development. It is highly likely that every county medical society should do the same, to research out needs and trends and to study possible courses of action.

As I attend medical meetings and hear about the accomplishments of research, I hope we can develop new ways to put the research to use even more effectively. John W. Knutson, M.D., president of the National Health Council, recently declared that "the U. S. Public Health Service has estimated that failure to use new research findings is responsible each year for 40,000 deaths from cancer, 20,000 deaths from rheumatic heart diseases, and for needless suffering of millions of persons from other ailments."

As physicians—active in practice, teaching and research—how can we do more to relate research findings through teaching and postgraduate education to the daily practice of medicine? Doctor Knutson has said that "a good share of the promises of health research over the past several decades is not being kept."

As we learn to better utilize the good work of research, we will b better able to cope with problems resulting from the urbanization tren

Today, it is not enough to practice the best medicine we know, and t participate in continuing education, we must also be active in con munity life. As physicians and citizens, we must take the leadership i community health planning and programming.

Luther R. Leader M.D.

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